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An Coiste um Chuntais Phoiblí

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Committee of Public Accounts

Report on the Health Service Executive

March 2013

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Chairman's Preface

I welcome the publication today of this Report on the HSE.

This Report is based on three hearings held by the Committee with the HSE in January, June and October 2012 where a range of issues that were the subject of a report to the Committee by the Comptroller and Auditor General were examined.

The HSE spends on average approximately €14 billion annually in the delivery of all our public health services. As an organisation it has faced huge problems not only in managing its budget and delivering quality health care but also in areas such as finance and HR where it is still trying to come to terms with the difficulties arising from amalgamating the old health systems and structures. The Report also deals with issues such as the review of the medical consultants' contract, the cost of drugs and the employment of agency staff, all of which were the subject of detailed examination at the three Committee meetings.

The recommendations made in this Report are aimed at tackling inefficiencies identified by the Committee during the course of our hearings. I would ask whether it is an efficient use of resources if:

- The State is paying a lot more for drugs than other comparable OECD States
- Medical Consultants can earn up to a full year's salary which is paid as a gratuity to those retiring just because they accumulated historic rest days
- Huge amounts of income due to the HSE are not being collected in a timely manner
- Staff of the HSE can retire on public sector pensions and return to work and fill their former posts as agency workers.

This Report also covers the development of primary care teams; a strategy has been developed to deliver primary medical care in the community. The key to developing the

system and it is clear, based on the evidence given to the Committee, that it is not working as good as it should be is to get buy-in from GPs and one way of achieving this is to link participation in Primary Care Teams to the award of GMS contracts. This may be the way forward.

Finally, a large portion of the HSE budget is allocated to voluntary bodies and the Accounting Officer voiced concern to the Committee that the oversight of this spend is not as comprehensive as he would like. That is a situation that cannot continue and the Committee has made certain recommendations that will enhance oversight of this expenditure.

I recommend this Report to Dáil Éireann.

John Mc Guinness TD
Chairman of the Committee
21st March 2013

Introduction

The Heath Service Executive was established in 2005, when the eleven health boards were amalgamated to form one single entity for the delivery of health services in the State. From its inception, it has faced difficulties as it tried to streamline services and to integrate the 100,000-plus staff into one efficient and effective organisation. While the early years of the HSE saw its employee numbers grow to a peak of 112,771 in September 2007, it has since reduced its employee headcount to 102,343 through various incentives and cost-cutting measures that were introduced following the economic downturn in the State from 2008 onwards. The HSE had gross expenditure of just under €14 billion in 2011. The PAC examination in 2012 arises from the 2010 Annual Report of the Comptroller and Auditor General where Chapters 41 to 48 dealt with issues arising from the audit of the HSE. These meetings were held on 26th January 2012, 28thJune 2012 and 9th October 2012 when the Accounting Officer of the HSE and his senior officials gave evidence to the Committee. In the case of the meeting of 9th October, 2012, the Accounting Officer of the Department of Health also gave evidence to the Committee. The debates of these meetings are available on the Committee website[1].

Accountability Issues

The accountability issues examined by the Committee were:

- Budgetary control measures at the HSE
- The PCRS, including the centralisation of the administration of medical cards
- Overview of expenditure by the voluntary sector (Section 38 & 39 bodies)
- The medical consultants' contract
- The development of primary care teams.

[1] http://debates.oireachtas.ie/committees/2012/AC.asp

Chapter One
Budgetary Control Measures

Introduction

Budget over-runs have been an annual feature in the finances of the HSE. In each year since its establishment, these budget over-runs were dealt with by way of supplementary estimate. While the tight economic situation of the State meant that recourse to a supplementary budget was not contemplated by the Government until the late in the year, the outcome for last year was that the Dáil had, once again, to approve a supplementary estimate in December 2012 . The whole budget management process of the HSE was reviewed by the Committee of Public Accounts of the last Dáil arising from Chapter 14 of the 2007 Annual Report of the Comptroller and Auditor General which raised concerns at allowing over-runs to develop and for the delay in taking corrective action as there was an expectation that budget holders would be bailed out. That approach had allowed a culture of "wait and see" to develop at senior management levels in the HSE. With the major deterioration in the public finances, and the commitments given by the State as part of the Troika bail-out, the scope available to the State to meet overruns has been severely restricted. At its meeting of 28th June, 2012, the issue of the looming budget over-run in 2012 was examined in the context of Chapter 47 of the 2010 Report of the C&AG which dealt with the management of the HSE Vote, given that there was a reported likelihood of an overrun of €500 million in 2012 if savings were not found. At end June 2012, the HSE was almost 5% over budget. In relating budget management and the Report of the C&AG, the Committee wanted to establish the way the over-run was being tackled in terms of controls in expenditure and in collecting income due to the HSE.

As a result of the publication by the HSE of figures in September 2012 which, when analysed, showed that the anticipated over-run remained on course to be somewhere in the region of €0.5 billion, the Committee took the unusual step of formally reopening Chapter 47 in order hear further evidence from both the HSE and the Department and this took place on 9th October, 2012. The key issue for the Committee at this and at the earlier meeting was to get a better understanding of how the vote was being managed given that there is a requirement under public financial procedures for public bodies to balance their budgets and having regard to the stated intention of the Government to the effect that extra resources would not be made available by way of supplementary estimate.

The meetings with the HSE and the Department did show up the vote management difficulties that confront the HSE, mainly due to demand-led activities and eligibility criteria that have been set by the State in areas such as medical cards. In that regard the HSE was able to point to the increased activity in our hospitals with more patients presenting for treatment and requiring hospitalisation and to the increase in the amount of drugs prescribed to medical card holders as the key contributors to the over-run in 2012. The Committee also noted certain measures that were outlined to the June meeting such as savings and anticipated income on which the budget of the HSE for 2012 was predicated did not materialise. This Report examines the steps taken in order to achieve a balanced budget and also examines issue of budgeting provision.

The Reason for the Budget Over-run in 2012

The Committee was informed that the overrun was attributed to the fact that there were increased levels of activity, especially in demand led schemes, unanticipated costs arising from the departure of staff and also to the fact that anticipated savings in certain areas proved optimistic.

Demand- led pressures

The main reasons the HSE ran into difficulty can be put down to the pressure placed on demand let schemes as outlined hereunder.

Hospital Activity

In evidence to the Committee at both the June and October meeting, the Accounting Officer outlined how activity at some of the major hospitals was higher than anticipated with acute admissions, which basically relates to those who attend the emergency department and required to be hospitalised, was running 6% ahead of anticipated levels. The Committee noted that there was a greater throughput of patients and that more patients were being treated as day-care cases. The problem of late discharges due to the unavailability of suitable step-down facilities added to the cost of hospitalisation and this is an issue that the Committee will keep under review. The fact that medical consultants will now be available at weekends may facilitate earlier discharges and this may also lead to lower costs.

Primary Care Reimbursement Service

The cost of treating those with medical cards also ran ahead of schedule and the final estimate was that the extra cost was €234 million. The number of medical cards holders increased by 39,000 more than anticipated. In addition, it was outlined to the October meeting of the Committee that higher rates of drugs were being prescribed and that some of this was due to the demographic profile of card holders who are growing older, living longer and requiring a larger range of drugs.

The number of medical cards issued has increased dramatically and in 2012, the number of card holders stood at almost 1.9 million. That is a 67% increase in the 2005 figure. Some of this increase can be attributed to an ageing population who are living longer and the other main factor arises from the economic downturn with a large cohort of people now qualifying for a card based on income criteria.

Un-anticipated costs

More staff than anticipated left the HSE in 2012 and while this led to payroll savings in the region of €60 million, it did give rise to lump sum payments of €235 million and therefore an extra cost arose for the HSE that had not been factored in at the time of the original estimates.

Savings that were not delivered in 2012

Budgeting is, by its nature, not an exact science and every year certain assumptions are made based on either the emerging trend in the service (hospital admissions, etc.) or based on the likely outcome of future negotiations. The Committee was informed at the June meeting that, in the case of the 2012 health budget, it was anticipated that there would be:

- €124 million saved in drug payments
- €140 million raised in extra income, of which €75 million would arise from charging private patients who are treated in public beds
- €100 million approximately through reduced use of agency staff where the budget was cut by 50%.

In all three areas, the savings did not materialise. Reliance on agency staff (doctors and nurses primarily) did fall by 10% and it is clear that in this case there was an unrealistic expectation on the part of the State that this saving could be delivered. On the cost of drugs,

while it would have been clear in 2011 that there was scope for savings until such savings are negotiated, it may not be prudent to put a figure on the anticipated savings. An Agreement that will see significant savings in the cost of drugs was agreed in late 2012, however this was too late to have a major impact on the 2012 spend.

Tackling the over-run

While the review of current day expenditure is not a matter for the Committee as it has not been subject to audit, the PAC has a role in ensuring that control and financial management systems are effective in public organisation. To that end, the evidence given to the meetings of the Committee in June and October gave a unique insight of real time adjustment endeavours of the HSE, in consultation with the Departments of Health and Public Expenditure and Reform, to tackling over-runs and take steps to achieve the ultimate goal of a balanced budget. Two aspects of this are dealt with in this report, namely a content issue which looks at the actual steps that are taken to balance the budget and the second is a process issue which looks at the adequacy of management information systems.

Budgetary measures

The Committee was informed that a number of cuts were being made to front line services which had the potential to deliver savings of €57 million and as this was a policy matter, it was outside the remit of the PAC. The other steps being taken by the HSE fall into a number of categories which were highlighted to the Committee at the October meeting. In addition the Committee examined issues such payroll savings, the tackling of legacy issues such as the full implementation of the medical consultants contract and savings in the cost of drugs. Under a separate heading, the Committee also reports on the financial management systems of the HSE.

Special measures taken to manage the Vote in 2012

The Committee was informed at the October meeting that, at the end of August 2012, the operating deficit, which is the difference between the actual spend and the targeted spend for this period was €404 million which was up from the €350 million at the end of July. On the basis of the monthly increase and without any corrective measures, the trend indicates that the end of year figure would be €505 million. The primary causes of this overrun, as per the evidence of the HSE, were attributed to an overspend in hospitals of €201 million, an overrun of the primary care reimbursement service of €150 million and by a shortfall in

anticipated income. The figures quoted above are relative to the end August 2012 position. The final outturn in respect of the Vote, as outlined to the Dáil in December 2012 , was that the HSE required a gross supplementary estimate of €360 million.

The HSE outlined the steps taken to correct this overspend, which included expenditure savings of €130 million. This included the €57 million from front line services outlined above and €73 million from non-front line services including procurement, cash management, stock management and travel. The other measures identified to the Committee related to the income streams, some of which were the subject of intense negotiations at the time of the Committee hearing and hence the HSE was restricted in the amount of detail it could give to the Committee. These in the main related to the income outstanding from the private health insurers, some further savings in the cost of drugs and from cash extracted from the hospital system through productivity gains from the increased availability of hospital consultants. As the Committee could not receive specific detail on these issues, it cannot report directly to the Dáil on their anticipated impact. The remainder of this Report will examine other issues, some of which impact on the budgetary position of the HSE, that were the subject of detail scrutiny by the Committee at its three hearings.

Income Collection

One of the key aspects of budgeting in the Irish health service is the collection of monies arising from service charges especially from the private health insurers in respect of private practice in public hospitals. At its October meeting, the Committee was informed that the HSE was due €219 million in respect of claims submitted to the private insurers and that on average it took 140 days to process payments. Consultants on average were taking between two and three months to sign off on forms which would enable claims to be submitted. What was of more concern to the Committee was the fact that at the October meeting, a figure of €74 million was outstanding in respect of claims that had not been signed off by the Consultants and that between €5 and €8 million of this was outstanding for over a year. While the issue here is primarily one of cash flow, the fact is that the HSE pays its own debts within 30 days and yet, for a significant portion of its own income, it had been waiting in excess of 200 days to receive payments and it was reliant on consultants to sign-off forms in order for hospitals to submit its maintenance charges. This is clearly unsatisfactory. The Committee welcomes the initiative negotiated at the LRC whereby claims will be signed off by consultants within 14 days of the patients' discharge which should see a significant

improvement in cash flow. The Committee also welcomes the installation of new IT system which are being rolled out to all our hospitals as this should significantly reduce the number of queries on claims that are in the system and thus facilitate earlier payment by health insurers. The Committee will review the progress being made in prompt collection of income when it reviews the 2011 accounts of the HSE in the April 2013.

Financial Management Infrastructure in the HSE

The inadequacy of the financial management information infrastructure in the HSE is a hindering factor that needs to be urgently addressed, specifically in the context of the budget returning to direct Departmental control in 2014. The Committee was informed that the HSE still relied on eight primary systems which are a legacy of the old health boards that existed prior to the 2005. Because there is not one unitary system, information has to be imported from these legacy systems into one central database to which is also imported over 50 sets of data from voluntary bodies. All the information is amalgamated to produce a single set of financial reports and this has to be done on a monthly basis. The new acting CEO of the HSE made it clear that the lack of this key infrastructure was contributing to the difficulties being experience annually by the HSE in delivering a balanced budget when he stated:

> **"***Over successive years, in what we believed were the good times and now know were not and the less good times, there were successive periods during which the HSE ran into financial difficulties at or about this time of year - sometimes a little sooner or a little later - so this is not a current year issue. I believe that the absence of contemporary accounting systems - unified accounting systems of the type one would expect to see in an organisation of this size and complexity - is a significant contributory factor to that challenge* **…"**

The Committee, at its October meeting, was informed that the Department of Health had commissioned the Ogden Report which examined the strengths and weaknesses of the HSE in respect of financial management. That report has not been published and the Department and the HSE are working on an implementation report and it is likely that a major investment will be required on systems in 2013. The Committee agrees with the view of the outgoing Accounting Officer (Mr Magee) that the current systems are not fit for purpose and will keep this issue under review in 2013 as it wants to see this critical issue addressed. The

Committee will recommend that the HSE publish an implementation plan in the first half of 2013 which outlines the way it proposes to tackle this legacy issue.

Chapter Two
Employment issues in the HSE

Introduction

One of the key methods adopted by the State to cut costs has been to reduce the overall number of public servants. That is achieved in the main through the moratorium on filling posts. The HSE, in addition to the moratorium, also introduced a voluntary redundancy package and a large number of staff retired early due to the pension changes that came into effect on 1st March 2012. In addition, 1000 Community welfare officers and some clerical support staff transferred from the HSE to the Department of Social Protection. The net effect of these measures is that, as at May 2012, the HSE staff headcount had been reduced by 10,500 from a high of 112,771 in 2007 to a 2012 figure of 102,343.

Payroll Reduction Measures

The Committee, at its meeting in January 2012, raised the issue of the extent to which savings are made through the lowering of headcount. Clearly, where an individual leaves employment and where that post is unfilled, there are significant long-term saving. The Accounting Officer did point out that, in the case of the HSE, the net savings amount to approximately 33% of the gross saving when account is taken of the loss of income through contribution levies and superannuation contributions and because the pensions costs, including lump sums, are met from the HSE Vote. As outlined to the Committee at the June meeting, the pressure on the HSE spend in June 2012 was partly due to the fact that more people than anticipated retired by the end of the pension grace period and this gave rise to unanticipated lump sum payments of €235 million which had to be met from the 2012 budget allocation and it also led to an increased demand for agency staff. The point that arises from this is that whilst cutting numbers in the public sector is the key part of the strategy of lowering costs, the real savings can be significantly lower where replacement costs arise. In an area like the HSE where the service costs can be predominantly related to labour costs, it is questionable whether early retirement packages and other inducement packages are cost-effective unless they are specifically targeted at areas where staff will not be replaced and where the retirements do not give rise to increased use of agency staff or to increased reliance on overtime.

Reducing the use of agency and retired staff

The HSE spends, on average, €200 million per annum on hiring agency staff. In the estimates process for 2012, it had been anticipated that the budget for agency staff could be cut by 50%, however, this anticipated saving proved unrealistic. That, in part, was due to the higher than anticipated levels of activity in our hospitals and also to the fact that there was a large number of retirements in a short space of time which proved problematic and required additional use of agency staff until services and staffing could be reconfigured. The Committee was also informed that under an EU ruling that came into effect in 2011, agency staff cannot be paid lower rates than a permanent equivalent grade staff member and, therefore, the whole issue of using agency staff, such as nurses, should be reviewed as there may be cases where the HSE and the hospitals in question should recognise that there is a need for a full-time post. What was of greater concern to the Committee was that staff retiring from the HSE can return to the same or a similar job though an agency. The HSE, while acknowledging that it is an issue which it has concerns about, cannot prevent this practice. The Committee is of the view that it is unfair that staff on public service pensions should be returning to work as they are evading the pension abatement rules that apply where a retired member of staff, in receipt of a pension, returns to the public service payroll. The Department of Public Expenditure and Reform should examine the possibility of having the pension abatement rules apply to agency workers. The Committee also finds it unacceptable that the HSE does not know how many of its former employees are back working in the HSE as agency staff. All citizens in this State have an RSI number, which works as a unique identifier, and all State bodies should be able to identify all those working for it through this unique identifier. It should be a mandatory part of all contracts with all agencies supplying staff to the public service that the RSI numbers of those workers should be given to the public body prior to taking up duty. Agencies should also be informed that, unless the situation is unique, retired staff on pensions should not be used.

In correspondence supplied to the Committee after the meeting on 28th June, the HSE has given the Committee a comparison between the cost of hiring agency staff as against directly employing a staff member (see Appendix 1). In effect, while there is a long-term saving in that the agency worker is not accruing pension entitlements and while it gives the HSE some flexibility in that for instance agency staffs do not get maternity leave, the overall costs are roughly similar. Therefore, in situations where there is an on-going requirement for agency

workers, the HSE should conduct a review with a view to having such posts filled by directly-employed staff. Such a move would circumvent the practice of retired staff returning to work in the service.

Chapter Three
Primary Care Services

Introduction

At present, there are approximately 1.9 million medical cards in circulation. The figures given to the Committee show that there has been a dramatic increase in the number of medical cards that have issued, especially since 2005. The cost of providing free or reduced-cost medical services is approximately €2.5 billion annually. The C&AG found that, in respect of the primary care reimbursement service (PCRS), €16 million had been paid out in 2010 in cases where the medical card had expired. In addition, GPs had been overpaid capitation grants to the tune of €3,095,000 in respect of medical card holders who had died. In addition, the whole administration of medical cards has changed to a centralised process and, while the administration process is now working better, the centralisation process caused a backlog to accumulate.

Overpayments

€572 million was paid to doctors and dentists in 2010 and clearly, given budgetary pressures, it is imperative that only payments based on entitlement are made in respect of medical card holders. The HSE is undertaking a comprehensive audit of the medical card database to catch duplicate cards and withdraw cards that are out of date. Under the new system of administration, there is automatic recoupment in respect of medical card holders who have died. However, there was a legacy issue whereby doctors were paid in respect of dead patients. The Committee had pressed that this money be recouped and the Committee understands that this has now happened. The HSE had not pursued the doctors for this money as it calculated that doctors were owed a roughly similar amount in respect of babies who are not registered at birth, however an exercise had been undertaken to deal with this legacy issue. On the issue of payments due to GPs for unregistered babies, the Committee will recommend that children who have an entitlement should be granted medical card cover from the date they first attend a doctor rather than from the date of birth. In this way, the capitation will more closely equate to the service provided.

Centralisation of medical card processing

The administration of medical cards was centralised to an office in Finglas in Dublin 11 with effect from 1st July 2011. Whereas in the past 450 staff were involved in the administration of

medical cards, that is now down to 150. The initial phase of the centralisation process did not work well. The unit in Finglas was under-resourced and clearly the steps necessary to have a smooth transition to centralisation had not been put in place. This resulted in considerable delays in the issue of medical cards and led to what can only be regarded as administrative chaos, with forms getting lost and old and sick people having to resubmit applications. By 1st January 2012, a backlog of 57,962 had built up and this, according to evidence given to the Committee, was cleared by April 2012. In order to streamline the application service and to make it as straightforward as possible to apply for a card, the Committee asked that the application form be reviewed and where possible simplified. Also, the centralisation should now enable the HSE to source a lot of information on applicants online from other Government Departments. Many applicants, for instance, will already be on the books of the Department of Social Protection and, by using the RSI number as a unique identifier, the HSE should be able to get key data without the applicant having to complete new forms.

Chapter 4
Services provided by the Voluntary Sector

Introduction

A large element of our health services is delivered by voluntary bodies under service level agreements with the HSE. The major bodies that work with the HSE are the sixteen voluntary hospitals and the other major service delivered by voluntary bodies relate to people with disabilities. In all, there are more than 2,500 separate agencies which operate 4,000 funding arrangements to the value of €3.4 billion per annum.

Oversight of expenditure by the Voluntary Sector

The Committee raised concerns in relation to the governance and oversight of these voluntary bodies and, in particular, the systems in place to ensure that these bodies are held accountable for the expenditure of public monies. HIQA has recently reported on governance arrangements in respect of Tallaght Hospital (AMNCH) and has recommended enhanced governance measures, and it is the Committee's view that such measures should be put in place forthwith in the sixteen voluntary hospitals. While the services provided by the voluntary sector are covered by service level agreements, the audited accounts of many of these bodies are not subject to detailed scrutiny by the HSE. These voluntary bodies do not, for instance, have to adhere to public service procurement practices or use framework contracts that have been put in place by the National Procurement Service: where the voluntary body had other sources of income, and some of these voluntary bodies would have a commercial element to their activities, it is not necessary to adhere to public service pay levels. While the situation is changing, especially in the case of the sixteen voluntary hospitals, it should be a condition of the grant of money that, for instance, these hospitals would use the framework contracts that have been put in place for the HSE in purchasing goods and services and that the pay of all staff would be in line with their counterparts in the public service.

The sixteen voluntary hospitals are statutorily independent of the HSE and two of these hospitals (Beaumont and St James) are audited by the C&AG. The Committee accepts that, in the case of these two voluntary hospitals, their status is different in that the Minister appoints the full board. Notwithstanding this differentiation, it is the Committee's view that there needs to be a greater level of consistency in respect of the oversight of public funds by

voluntary hospitals given that approximately €1.9 billion is allocated to these sixteen hospitals and having regard to the HIQA findings in respect of Tallaght Hospital. The Committee will recommend that the audit, oversight and accountability arrangements of the fourteen voluntary hospitals be reviewed by Department of Health to determine the scope that exists for a Ministerial input into the appointment of the auditors, the board and the composition of board audit and remuneration committees at these hospitals. In that regard, while the Committee would favour an arrangement similar to that pertaining to the Universities which are audited by private firms and where the C&AG conducts a separate audit which avoids duplication but which examines additional elements of the audit which normally relate to testing the obligations which attach to such bodies in receipt of substantial funding from the State, it recognises that such an arrangement would have resource implications and will not propose such a measure as the costs could prove to be prohibitive.

In the case of the other voluntary agencies (commonly referred to as Section 39 agencies), the evidence given to the Committee suggests that the oversight arrangements in place for such bodies remains too sketchy. While work is progressing on developing service level agreements, the HSE has admitted that these bodies are not subject to audit by the HSE on a regular or programmatic pattern that should be a basic requirement in the oversight of public funds. Given the diverse nature of such agencies with some being small community based services, whose agreement with the HSE is based on local arrangements, whereas others are large bodies such as those providing community and continuing care, the oversight arrangements cannot be a one size fits all. The HSE should review its oversight and accountability arrangements for Section 39 agencies and strengthen its service level agreements in terms of remuneration, procurement and governance requirements. A system of random audit of a small percentage of these bodies may also prove useful in getting certain levels of assurances in respect of the use of public funds. The results of such random audits should outline trends in the level of compliance of these bodies with the service level agreements and would also give valuable feedback to the HSE which it could use to target its oversight enhancement programme.

Chapter Five
The medical consultants' contract

Introduction

The Committee was informed at its October meeting that the State was involved in negotiations with the representatives of the hospital consultants and as these negotiations were at a critical stage at the time of the October meeting, the Committee did not want to prejudice the outcome of the negotiations and will review the outcome of these negotiations at future examinations of the accounts of the HSE. There are a number of issues that were raised at the June meeting relating to pay and to the payment for rest days which the Committee wants to report on and which require more detailed follow up.

Pay of Consultants

The pay rates for medical consultants were agreed in 2008 after a number of years of protracted negotiations. Other than Type A contracts, consultants can engage in private practice and, in general, they are obliged to work 37 hours per week in public duty. The Committee was informed that while 37 hours was the minimum requirement, many consultants work well in excess of that figure. Consultants are paid, on average, €200,000 in respect of their 37 hour contractual obligations. There are over 500 consultants in receipt of these salary levels. The Committee notes that in the UK, where consultants have no access to private income, the rates of pay are much lower. A threshold 1 consultant in the NHS has a starting salary of £74,000 and this rises to threshold 8 consultants who earn £100,000. A top consultant who has a platinum recognition in clinical excellence is paid £175,000. The Committee has been made aware that levels of remuneration for higher paid public servants will be reviewed as part of the 2013 negotiations that are underway whose aim is to secure a further cost savings in the public sector. Given what appears to be a large disparity between the pay of Irish medical consultants in comparison to their counterparts in the UK, it may be appropriate for some benchmarking exercise to be undertaken so as to determine an appropriate rate of pay for medical consultants who are on the States pay-roll.

Payment for rest days

The Committee also questioned the practice of paying up to an extra year's salary to retiring consultants who have accumulated rest days. In 2010, for instance, one consultant was paid an allowance of €186,000 in lieu of historical rest days that had been accumulated over the

career of the consultant. The HSE has, since the meeting in June, supplied details in respect of 2011 which show that 31 consultants were paid sums ranging from under €15,000 to as high as €200,000 (see Appendix 3). In all, eight consultants were each paid over €175,000. The total cost of this payment in 2011 was between €2.6 million and €3.14 million. The Committee is of the view that such payments are difficult to justify and will recommend a change in the way historical rest days can be carried forward from year to year. The Committee recommends that, similar to the rules relating to the carry forward of annual leave in the civil service, rest days should be used within a three-year cycle or otherwise lost. It is the Committees view that no allowance should be paid for untaken rest days at retirement except for those that have accumulated in the current three year cycle.

Chapter Six
Cost of Drugs

Introduction

The Irish State pays a lot more for drugs than other comparable States. Evidence given to the Committee shows that whereas between 16% and 17% of the HSE budget is spent on the purchase of drugs, the NHS figure is only 9%. The HSE estimates that if the price of both on and off patent medicines were reduced to UK equivalent prices, a saving of €50 million would result. The Committee was also told that the States spend on pharmaceuticals is disproportionate when compared to the OECD average and to a number of comparator countries. One of the reasons for this is that there is a tendency for GPs to prescribe branded expensive drugs and until now, pharmacists did not have the freedom to dispense less expensive interchangeable drugs. However the main reason for the high costs has been the ability of the pharmaceutical industry set the price levels here and therefore, getting an agreement which will reduce the cost to the HSE of both branded and generic drugs is an essential element of budget control.

Anticipated savings in 2012

The budget plan for 2012 anticipated savings of €124 million in the cost of drugs, however agreement was not reached with the pharmaceutical industry to deliver savings of this magnitude until later in the year and the Committee was informed in June that an interim agreement that would bring about annual savings of €20 million was reached. As outlined in Appendix 2, the State has now reached an agreement with the Irish Pharmaceutical Health Care Association which is estimated to lead to savings of €113 million in 2013.

At the time of publication, the negotiations aimed at further costs reductions with the Association of Pharmaceutical Manufacturers of Ireland, which represents the generic drugs industry had not concluded. The Committee notes that the Health (Pricing and Supply of Medical Goods) Bill 2012 will, when enacted, provide for both generic substitution and reference pricing, whereby the patient is given the choice of being prescribed the more expensive branded product but will have to meet the price difference. The Committee will monitor the impact of this measure, as well as the impact of the agreements with the pharmaceutical industry, in reducing the cost of drugs in 2013.

Chapter Seven
The development of primary care teams

Introduction

Primary care in Ireland is delivered predominantly by independent GP practices and by community nurses who deliver health care services in the homes of patients where their condition does not necessitate hospitalisation. Dating back to 2001, the primary care strategy has been to get GPs, Community Nurses and other services such as dieticians and various therapy services working together in multidisciplinary teams where they would also be, ideally, co-located. The primary care strategy has been revisited a number of times since 2001 and the target now is to have 489 teams in place. The HSE gave an update on the development of primary care teams to the Committee at its meeting in January 2012. At the time the functioning of the new primary care team structures could best be described as being patchy.

Roll-out of Programme

In terms of progress, at the end of 2011 there were 425 teams in operation, which is 87% of the target. These teams provide services to a population of 3.4 million with more than 3000 staff and in excess of 1,592 GPs participating. The assessment of the HSE was that:

- one third of these primary care teams were working extremely well
- one third are average and
- the remaining third is not working effectively.

It did not help the effectiveness of teams that only 8% of teams are in co-located facilities. It is clear, based on this assessment that a lot of work needs to be done in order that the primary care system works more effectively. It is also clear that the key to a successful PCT is the involvement of GPs. Under the current system GPs are encouraged to join, however, there appears to be some unwillingness on the part of GPs to engage fully in the process, especially when it comes to attending multidisciplinary meetings where care plans are developed for patients. As the PCT approach is the States preferred way forward, especially when developing community-based care for patients (a good example cited to the Committee was the professional care path for patients with diabetes), the State has to do more to get these PCTs fully functioning. One lever available to the State is the GMS contract where GPs and

dentists receive annual payments in the region of €570 million. As the State sees the PCT system as the most effective way of delivering primary care and as it should lessens the reliance on hospital service, the Committee will recommend that the State review the award criteria for the GMS contract so that those GPs who are part of a PCT and whose patients are in return getting a more holistic service are given priority in the award of new GMS contracts.

Chapter Eight
Findings and Recommendations

Findings

1. The HSE, having been over-budget from a very early stage in 2012, required a supplementary budget of €360 million in 2012 in order to balance its books.
2. The 2012 budget of the HSE had built in anticipated savings of €364 million in respect of drug payments, extra private income and the use of agency staff and these savings did not materialise.
3. The financial management infrastructure currently available to the HSE comprises of legacy systems from the old health boards and this infrastructure is no longer fit for purpose.
4. The HSE is not in a position to identify the number of its former staff who are now employed as agency staff and working in the public health system.
5. The cost of employing an agency worker is similar to the cost of directly employing that worker.
6. The application form for the medical card is unnecessarily complicated.
7. The centralisation of medical card processing in July 2011 led to administrative chaos, with a backlog of 58,000 applications built up by 1st January 2102. That backlog has since largely been cleared.
8. The oversight and accountability arrangement in respect of the €3.4 billion of the HSE budget that goes to the voluntary sector is weak and needs to be reviewed.
9. Sixteen voluntary hospitals receive approximately €1.9 billion in grants from the HSE annually: Only two of the sixteen hospitals are audited by the C&AG: the remaining 14 hospitals are audited privately thus making their boards and executive unaccountable to the Committee of Public Accounts.
10. The HSE was awaiting the sign-off of paperwork by Hospital Consultants which was holding up payment of €74million at the end of September 2012. Between €5million and €8million was in respect of services which had been provided over 12 months previously.
11. The HSE paid out over €2.6 million in allowances to 31 Hospital Consultants who retired in 2011 in lieu of historic rest days that had been accumulated by the consultants during their careers. A payment of over €175,000 each was made to eight of these Consultants.

12. The level of pay of Hospital Consultants in Ireland is substantially more than that paid to their counterparts in some other jurisdictions.
13. Over 16% of Ireland's health budget is used to purchase drugs whereas in the UK, the figure is 9%
14. A sum of €50 million would be saved annually if the price the HSE paid for drugs was the same as the price paid by the NHS in the UK.
15. Of the 425 primary care teams in place at the end of 2011, only 33% were functioning extremely well.
16. The development of effective primary care teams is contingent on the participation of GPs. The HSE cannot force GPs into participating in PCTs.
17. Under the GMS, GPs are paid from the date of birth of babies that have medical card qualification

Recommendations

1. A review of the budgeting model that was used to determine the budget allocation of the HSE in 2012 should be undertaken by the Department of Public Expenditure and Reform, given that some of the anticipated savings in areas such as the use of agency staff did not materialise.
2. Where an estimate presented to the Dáil contains expenditure figures that are predicated on the outcome of future negotiations, the relevant Minister should be required to inform the Select Committee of the envisaged timescale for such negotiations and should also give a progress report at regular intervals to the Select Committee.
3. The Department of Health having completed its review of the Odgen Report which examined the financial management capacity of the HSE should publish an implementation report which will outline the investment strategy on financial management infrastructure so that the State has a robust and workable system for the management of the health budget.
4. The HSE should establish, based on usage and on-going need, the number of posts that could be filled directly rather than through use of agency workers on a cost neutral basis.
5. The Department of Public Expenditure and Reform should examine whether the pension abatement rule can be extended to cover agency workers.

6. The application form for the medical card should be reviewed to make it straightforward and user friendly.
7. The HSE should establish whether information on applicants for medical cards which is held by other Government agencies can be made available online to the HSE in order to streamline the application process and should take steps to obtain such information on-line where it is possible to do so.
8. The recommendations made in the HIQA Report on Tallaght Hospital (AMNCH) in respect of governance and oversight should be set as the minimum standard expected of all voluntary hospitals and the service level agreement between the HSE and the relevant voluntary hospital should reflect these requirements.
9. The Department of Health should review the audit arrangements for the voluntary hospitals that do not currently fall within the remit of the C&AG so as establish the scope that exists to enhance the accountability of those hospitals to Dáil Éireann in respect of the €1.9 billion annual grant received from the State. This review should examine the extent to which the Minister for Health can have a greater role in the appointment of the auditors, the board of each hospital and the membership of the each board's audit and remuneration committees.
10. The HSE, in consultation with the Department of Health, should conduct a review of the oversight arrangements in respect of the 2,500 agencies who receive funding under Section 39 and should examine whether a system of random audit of a percentage of those bodies would enhance oversight.
11. The HSE should examine the scope it has to publish the names of those Hospital Consultants who are holding up the collection of income due to the HSE from private insurers.
12. The practice of paying allowances to retiring hospital consultants in lieu of untaken rest days should be reviewed. A provision should be introduced whereby consultants can carry forward untaken rest days within a three year cycle, similar to the civil service provision relating to annual leave.
13. As part of the review of remuneration of higher paid public servants, the Department of Public Expenditure and Reform should conduct a benchmarking exercise in respect of the pay of Hospital Consultants
14. As part of the on-going drive to reduce the cost of drugs, the prices paid by the State should be benchmarked against the prices paid by the national health services in other

OECD States. The results of this simple benchmark process should be published annually.

15. The Department of Health and the HSE should review the GMS contract with a view to establishing whether criteria relating to GP participation on primary care teams can be a factor in determining the award of new contracts.
16. The GMS contract should provide that medical card entitlement of babies be established from the date they first attend a GP and not the date they were born.

Appendix 1

Note from the Health Service Executive on comparisons between the cost of hiring agency staff as against directly employing a staff member (extract from letter dated 19th July 2012)

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

PAC-R-593

Correspondence 3A.7
Meeting – 20/09/2012

Health Service Executive
Parliamentary Affairs Division
Block D, 2nd floor
Parkgate Business Centre
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Web: http://www.hse.ie/go/rialtas

19th July 2012

Ms. Fiona Cashin,
Committee Secretariat,
Committee of Public Accounts,
Leinster House,
Dublin 2

Dear Ms. Cashin,

I refer to your letter regarding our attendance at the recent Public Accounts Committee meeting with the HSE and a request for information on a number of follow up issues that arose during the course of the Committee's examination.

Please find here under for the attention of the Committee the HSE responses to the matters raised. We are gathering information for the remaining issues and will respond to you shortly.

I trust this information is of assistance.

Yours Sincerely,

Ray Mitchell

Ray Mitchell
Assistant National Director
Parliamentary & Regulatory Affairs

1. A note providing a comparison in costs between employing a nurse directly as against engaging an agency Nurse (see also 7 below).

Response:

Background -
In March 2011 the HSE introduced agency contracts for the provision of HealthCare staff in the following Categories:

- Nursing
- Medical (NCHDs and Consultants)
- HealthCare Assistants
- Allied Health Professionals
- Social Care Workers.

The tender process resulted in significant savings on the cost of agency staff as follows:

Category	Savings from Pre -Tender Prices
Nursing	24.41%
Medical	18.94%
Allied Health Professional	19.96%
Social Care Workers	20.97%
Health Care Assistants	19.29%

The Protection of Employees (Temporary Agency Work) Act 2012 was enacted in May 2012. The implementation of this act requires that Agency Staff are treated 'as if' they were hired directly meaning that they must receive equal pay and other listed benefits in the same manner as directly employed staff members. The full impact of this act is not fully known as of yet, however it is expected that it will result in a significant increase in the cost of agency staff to the HSE.

- Agency Staff are only entitled to annual and public holiday leave, directly employed staff figure includes other statutory leave e.g. Maternity leave.
- Superannuation Figure is as per DOHC guideline.

Comparison in Costs between employing a nurse directly against employing an agency Nurse.

The Cost of employing agency staff is as follows:

Salary to Agency Staff member + Annual Leave/Public Holiday Leave + Employers PRSI (10.75%) + Agency Fee + VAT (23%)

Salary and Annual Leave are now in line with what a direct employee is paid as is employers PRSI. The additional Cost is now the VAT @ 23% plus the agency fee which ranges from 5.5% - 8%. It is important to note that agency staff are not in receipt of allowances or superannuation payments, so this will offset the overall cost.

As agency nurses will not generally work a full 39 hour week it is difficult to compare the actual salary of an agency nurse against a directly employed nurse, please see below in relation to Cost Components for analytical purposes.

Cost Component	Agency Nurse	Directly employed Nurse
Pay	DOHC Salary Scale	DOHC Salary Scale
Premium Pay	DOHC Salary Scale	DOHC Salary Scale
Employers PRSI	10.75%	10.75%
Superannuation	0%	25%
Leave Factor*	16.09%	20%
VAT	23%	0%
Average Agency Fee	5.60%	0%
Total % increase on Salary	55.44%	55.75%

- Agency Staff are only entitled to annual and public holiday leave, directly employed staff figure includes other statutory leave e.g. Maternity leave.
- Superannuation Figure is as per DOHC guideline.

Appendix 2

Note from the Health Service Executive regarding the new deal on the cost of drugs with the Irish Pharmaceutical Association

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

PAC-R-704

Correspondence 3A.2
Meeting – 01/11/2012

Health Service Executive
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Block D, 2nd floor
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Dublin 7

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25th October 2012

Mr. Ted McEnery,
Clerk to the Committee,
Committee of Public Accounts,
Leinster House,
Dublin 2.

Dear Ted,

I refer to recent correspondence from the Committee in relation to the outcome of the recent agreement with the Irish Pharmaceutical Health Care Association.

I attach for the Committees attention as requested a note on the matter.

If any further information is required please do not hesitate to contact me.

Yours sincerely,

Ray Mitchell

Ray Mitchell
Assistant National Director
Parliamentary & Regulatory Affairs Division

Note on the new deal on the cost of drugs with Irish Pharmaceutical Healthcare Association (IPHA) - 15th October 2012

The HSE and the Department of Health on the 15th October reached a successful conclusion with the Irish Pharmaceutical Healthcare Association (IPHA) on a new deal on the cost of drugs in the State.

The new deal, with a value in excess of €400 million over the next three years, will mean

- significant reductions for patients in the cost of drugs,
- a lowering of the drugs bill to the State,
- greater access to new cutting-edge drugs for certain conditions, and
- an easing of financial pressure on the health services into the future.

The deal is beneficial in two broad ways,

1. about half the financial value is related to reductions in the cost of patent and off-patent drugs
2. the other half is related to the State securing the provision of new and innovative drugs for the duration of the agreement.

Amongst the measures that were agreed include;

- the price of medicines marketed by IPHA companies which are off-patent prior to 1st of November 2012 will be reduced to 50% of their original price by 1st November 2013;
- the price of up to 400 patent protected products which have been available on the HSE Community Drug Schemes prior to 2006 will be subject to a price review. Price reductions averaging up to 16 % are expected from this review process.

The new deal, combined with the IPHA agreement reached earlier this year, means that €16 million in drug savings will be made this year with much greater savings to be achieved in 2013/14/15. It is estimated that the deal will generate savings of up to €116m gross in 2013.

Previous agreements reached with IPHA on reductions in the price of medicines have accumulated savings in excess of €600 million for the taxpayer since 2006.

The Department and the HSE will shortly finalise discussions with the Association of Pharmaceutical Manufacturers in Ireland, which represents the generic drugs industry, to deliver further savings in the cost of generic drugs.

In addition, a National Task Force on Prescribing and Dispensing has been established to deal with prescribing and dispensing of medicines. It will address this issue from the perspective of quality and patient safety primarily, however, it can be anticipated that the work of this Task Force will also deliver significant cost savings in terms of achieving more cost conscious prescribing. The work of the Task Force will be wide ranging and include providing advice and guidance and support to prescribers and dispensers to help them improve prescribing practices and assessing the suitability of maintaining supply of certain items with limited efficacy where more appropriate items are available.

Health Service Executive
2012

Appendix 3

Note from the Health Service Executive regarding payments made to hospital consultants in lieu of historical rest days

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

PAC-R-594

Correspondence 3A.8
Meeting – 20/09/2012

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7th August 2012

Ms. Fiona Cashin,
Committee Secretariat,
Committee of Public Accounts,
Leinster House,
Dublin 2

Dear Ms. Cashin,

In my response to you on the 19th July 2012, the HSE submitted a series of replies to a number of follow up issues from our appearance at the recent PAC meeting and indicated that we were working on the remaining issues.

In that regard please find here under for the attention of the Committee the HSE responses to the outstanding issues raised.

I trust this information is of assistance.

Yours Sincerely,

Ray Mitchell

Ray Mitchell
Assistant National Director
Parliamentary & Regulatory Affairs

2. A note outlining the savings that will be achieved on the cost of medicines for 2012.

Response:

The National Service Plan 2012 set out the policies, supported by legislative changes, to provide scope for driving further reductions in drug pricing. These initiatives were designed to generate full year savings totalling at least €100m this year. Their delivery was dependent upon agreement with the Irish Pharmaceutical Healthcare Association (IPHA) among others together with the enactment of the requisite legislation by Government. These savings have not yet been delivered as negotiations to date have failed to achieve the requisite quantum of savings. Additionally, the National Service Plan 2012 did not provide additional funding for the introduction of new drugs during 2012. The decision to introduce new drugs creates an additional cost pressure for Schemes which will have to be considered in the context of total Schemes expenditure this year

3. A note outlining the difference between what the HSE pay for medicines and what the NHS pays for similar drugs.

Response:

It has been estimated that if the prices of both on and off patent medicines were reduced to UK equivalent prices, a saving of €50m would result. The currency position, at the time a comparison is made, impacts on the estimate.

11. A breakdown within ranges stating the amount of allowances paid from the Vote in 2010 in relation to rest days claimed by hospital consultants.

Response:

With regard to the taking of Historic Rest Days by Consultant Medical Staff, a total of 31 doctors were beneficiaries of this arrangement in the year ending 31st December 2011. The following are the numbers within particular pay ranges:

Number	Amounts Range
4	190 – 200k
4	175 – 190k
1	150 – 175k
2	125 – 150k
4	100 – 125k
3	75 – 100k
2	50 – 75k
3	25 – 50k
4	15 – 25k
4	Less than 15k

Appendix 4

Orders of Reference of the Committee of Public Accounts

(1) There shall stand established, following the reassembly of the Dáil subsequent to a General Election, a Standing Committee, to be known as the Committee of Public Accounts, to examine and report to the Dáil upon—

(*a*) the accounts showing the appropriation of the sums granted by the Dáil to meet the public expenditure and such other accounts as they see fit (not being accounts of persons included in the Second Schedule of the Comptroller and Auditor General (Amendment) Act, 1993) which are audited by the Comptroller and Auditor General and presented to the Dáil, together with any reports by the Comptroller and Auditor General thereon:

Provided that in relation to accounts other than Appropriation Accounts, only accounts for a financial year beginning not earlier than 1 January, 1994, shall be examined by the Committee;

(*b*) the Comptroller and Auditor General's reports on his or her examinations of economy, efficiency, effectiveness evaluation systems, procedures and practices; and

(*c*) other reports carried out by the Comptroller and Auditor General under the Act.

(2) The Committee may suggest alterations and improvements in the form of the Estimates submitted to the Dáil.

(3) The Committee may proceed with its examination of an account or a report of the Comptroller and Auditor General at any time after that account or report is presented to Dáil Éireann.

(4) The Committee shall have the following powers:

(*a*) power to send for persons, papers and records as defined in Standing Order 83(2A) and Standing Order 85;

(*b*) power to take oral and written evidence as defined in Standing Order 83(1);

(*c*) power to appoint sub-Committees as defined in Standing Order 83(3);

(*d*) power to engage consultants as defined in Standing Order 83(8); and

(*e*) power to travel as defined in Standing Order 83(9).

(5) Every report which the Committee proposes to make shall, on adoption by the Committee, be laid before the Dáil forthwith whereupon the Committee shall

be empowered to print and publish such report together with such related documents as it thinks fit.

(6) The Committee shall present an annual progress report to Dáil Éireann on its activities and plans.

(7) The Committee shall refrain from—

(*a*) enquiring into in public session, or publishing, confidential information regarding the activities and plans of a Government Department or office, or of a body which is subject to audit, examination or inspection by the Comptroller and Auditor General, if so requested either by a member of the Government, or the body concerned; and

(*b*) enquiring into the merits of a policy or policies of the Government or a member of the Government or the merits of the objectives of such policies.

(8) The Committee may, without prejudice to the independence of the Comptroller and Auditor General in determining the work to be carried out by his or her Office or the manner in which it is carried out, in private communication, make such suggestions to the Comptroller and Auditor General regarding that work as it sees fit.

(9) The Committee shall consist of thirteen members, none of whom shall be a member of the Government or a Minister of State, and five of whom shall constitute a quorum. The Committee and any sub-Committee which it may appoint shall be constituted so as to be impartially representative of the Dáil.

Appendix 5

Membership of the Committee of Public Accounts – 31st Dáil

Connaughton, Paul J. (FG)

Deasy, John
(FG)

Donohoe, Paschal
(FG)

Dowds, Robert
(Lab)

Fleming, Seán
(FF)

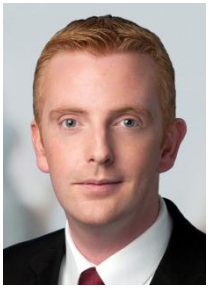
Harris, Simon
(FG)

McDonald, Mary Lou (SF)

McGuinness, John
(FF) – *Chairman*

Murphy, Eoghan
(FG)

Nash, Gerald
(Lab)



Nolan, Derek
(Lab)

O'Donnell, Kieran
(FG) – *Vice Chairman*

Ross, Shane
(Ind)