DÁIL ÉIREANN

AN COISTE UM CHUNTAIS PHOIBLÍ
COMMITTEE OF PUBLIC ACCOUNTS

THIRD INTERIM REPORT ON THE 2006 REPORT OF THE COMPTROLLER AND AUDITOR GENERAL

EXPENDITURE ON HEALTH SERVICES

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Chairman's Preface

This Third Interim Report on the 2006 Report of the Comptroller and Auditor General examines expenditure by the State in our health services, which the Committee dealt with at two public meetings this year with the Accounting Officer of the Department of Health and Children, the Chief Executive Officer of the Health Service Executive and the Chief Executive Officer of the National Treatment Purchase Fund. Following on from those hearings, the Committee is recommending measures that will improve the efficiency and effectiveness of those bodies that are charged with delivering health services on behalf of the State.

As Chairman, I want to thank the Members of the Committee for their hard work in dealing with this matter and also the staff of the Committee for their assistance in compiling this report.

The Committee recommends this report to Dáil Éireann.

Bernard Allen, T.D.,
Chairman.

November, 2008

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Executive Summary

The state of our health services is a central issue in public debate in Ireland and it will retain that central position as all involved try to deliver a service that provides optimal satisfaction to the citizens of the State. The Committee of Public Accounts is charged with reviewing the way money that was voted by Dáil Eireann for the procurement of health services was spent. It is assisted in this process by the annual audit and the annual report of the Comptroller and Auditor General. The purpose of the Committee's review is to address areas where inefficiencies are highlighted and to make recommendations based on its findings. This report covers a number of specific issues that arose during its examination and, in as simple and straight forward a manner as possible, makes a number of recommendations that deal with the following areas:

- The need to capture data on activities that will enable comparisons especially on performance at hospital level and that ultimately will lead to more effective decision making on resource allocation
- The need for greater transparency in the area of private practice by consultants
- The need for the Health Service Executive to present its financial statements in a more transparent format
- The need to ensure that there is full utilisation of the assets and facilities of the HSE
- The need to ensure that budgets for specific projects cannot be used to off-set shortfalls in other areas of the health sector
- The need to strengthen the remit of the National Treatment Purchase Fund in order to reduce waiting lists
- The need to introduce measures that will reduce the cost of drugs.

The HSE which is charged with delivering the public health care in the State has a huge remit that extends from the provision of facilities that allow acute life saving operations in our hospitals down to the provision of home help to the elderly people living in our communities. With current costs of €12 billion and a workforce of 110,000 people, it has to have the proper structures and systems to manage its resources so that it can deliver an efficient health service to the citizens of the State. This report is based purely on the Committee's hearings and is not a comprehensive analysis of issues affecting the health sector. The Committee has a specific remit and cannot question government policy, but it does highlight waste and inefficiencies and it does make recommendations to the Minister for Finance which will improve our health services. The Committee will continue to monitor health expenditure and will focus on other areas of expenditure in future examinations when it will also review progress on issues identified in this Report.

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Chapter One: Introduction

1.1 PROCEEDINGS OF THE COMMITTEE

The Committee heard evidence from the Comptroller and Auditor General and the Department of Finance and from the following witnesses and their officials:

- Mr Michael Scanlon, Secretary General, Department of Health and Children on 7th February 2008 and 29th May 2008;
- Mr Brendan Drumm, Chief Executive Officer of the Health Service Executive on 7th February 2008 and 29th May 2008;
- Mr Pat O'Byrne, Chief Executive Officer of the National Treatment Purchase Fund on 29th May 2008.

Note that the transcripts of all the above meetings are available on the Houses of the Oireachtas website.

1.2 BACKGROUND

Health expenditure is the largest element of Government spending and accounts for 25 % of current public expenditure. In 2006 the HSE accounts show current expenditure of €12 billion, of which €9.5 billion was funded by the exchequer with a further €1.2 billion coming from health contributions. The HSE also spent €457 million on capital expenditure in 2006. In addition the Dáil voted €363 million to the Department of Health and Children and €78 million of this was allocated to the National Treatment Purchase Fund (NTPF). Much of the overall spend on health is allocated to day to day salaries of the staff who deliver health services and the HSE is by far the largest employer in the State with 110,000 employees. Consultants' salaries alone in 2006 amounted to €350 million. In addition €5.8 billion has been earmarked for public sector capital developments for the period 2007 to 2013 under the National Development Plan.

A glance at the outputs gives a balanced picture of our health services and evidence given to the Committee in respect of 2006 shows that public acute hospital services dealt with over 590,000 inpatient discharges, over 550,000 day cases, over 1.2 million accident and emergency attendances and over 2.7 million outpatient attendances. The Committee was also apprised of some of the challenges facing the health services many of which arise from the fact that demographic trends will see an aging population and, as people now live longer, there will be an ever increasing demand on health services.

In examining the 2006 accounts, the Committee's primary focus was on deployment of resources that achieve an optimum return for the investment by the tax payer and a necessary element of that examination was to deal with the way data was captured and financial information presented by the bodies concerned.

1.3 THE ACCOUNTABILITY ISSUES

The accountability issues examined by the Committee were:

1. Effective deployment of resources and the need for performance indicators
2. Consultants' Contracts
3. Charges for private beds in public hospitals
4. Full utilisation of facilities/assets
5. Presentation of Financial Accounts and Financial Controls
6. The operation of the National Treatment Purchase Fund
7. Cost of drugs under the General Medical Scheme (GMS).

Chapters 2 to 8 will examine these seven accountability issues.

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Chapter Two:

Effective deployment of resources and the need for performance indicators

2.1 INTRODUCTION

Chapter One gave a brief outline of the resources that are deployed by the State to deliver public heath services in Ireland. The task of those charged with managing that resource is to ensure that it is deployed as efficiently as possible so that the outcome is an effective health service. Some of the problems in the health sector arise from the structures that pertain in our health services, one of which relates to the fact that the HSE is an amalgamation of eight health boards, which, three years after its creation, is itself now being restructured. At hearings of the Committee, problems where key players in the health services adopt positions that seek to protect vested interests which inhibit the efficient delivery of services were also highlighted. The Committee examined a number of issues in this area including:

- The need to match workload to resources
- The need to develop performance indicators which will underpin the allocation of resources at hospital level and community level.

2.2 MATCHING WORKLOADS TO RESOURCES

The Committee was informed that the delay in opening the new Accident and Emergency Unit at the Mercy Hospital in Cork was in the main due to a dispute about staffing levels. This is an example of problems that arise when there is no established benchmark which dictates the manpower needs of a hospital based on projected or actual throughput of patients and evidence given to the Committee shows wide disparities between hospitals when attendance and the number of staff in such hospitals are compared. The absence of agreed benchmarks is a weakness in the system which needs to be addressed by the HSE. Another example of this related to the high level of overtime payments to junior hospital doctors where they were on call in areas where the call in was very low, which is a structural issue that must be addressed. Also the need for human resources underpins planning decisions on student places on medical professional courses such as nurses, doctors and therapists as there is a need to have capacity available to meet medical needs and, conversely, to have employment prospects for those who commit themselves to working in the area by gaining a professional health related qualification. It is clear from the evidence given to the Committee that not all issues relating to the use of manpower are aligned within the health sector and this is leading to large scale inefficiencies.

The Committee accepts that, in the case of public hospitals, the service is demand led and capacity has to be in place to meet demands. There are also structural problems which prevent the rationalisation of service delivery which can result in waste of resources. The Departments of Finance and Health and Children and the HSE must address this issue through the establishment of baseline indicators and, where necessary, studies

should be undertaken which take account of best international practice. In particular, the concept of whole life costs, which covers both the capital investment and the annual running costs, should be adopted before major capital projects are signed off. The Committee is anxious that this process commence and will pursue the issue with the HSE.

2.3 PERFORMANCE INDICATORS AT HOSPITAL LEVEL

Budgets are allocated to public and voluntary hospitals based on service level agreements with the HSE. The culture in the public sector is that resource allocations are based on negotiations where the focus is very much on inputs and where the baseline is the budget given in the previous year. Negotiations on budgets take account of current levels of employment in such hospitals and also on the numbers on waiting lists. This focus on inputs makes comparative analysis difficult if not impossible. The Committee would like to see a situation whereby decisions on resources are based on activity levels and where there are incentives to improve on performance. Comparative analysis where the performance of say two hospitals can be compared is key to this and this can only happen where appropriate returns are made by all hospitals. The problem up to now has been that, while a lot of data is collected, it is treated in an unconnected fashion and key decision makers do not have access to analysed data that would make for effective decision making. The Committee noted that, as part of the HSE's Transformation Programme 2007-2010, an integrated statistical system (HealthStat) will be used to collect and connect such information. This should enable standards and benchmarks to be set and should be a major driver of efficiency in the system. The Committee will follow up on this with the Department and the HSE to ensure that progress is being made in establishing benchmarks which underpin decision making on resource allocation.

2.4 FINDINGS AND RECOMMENDATIONS

The Committee finds specifically that:

1. The HSE has not developed systems which allow staff to be matched with activity levels
2. The absence of staffing level benchmarks may have contributed to the delay in the provision of much needed services such as at the newly developed A & E unit at the Mercy Hospital Cork
3. The HealthStat initiative outlined in paragraph 2.3 may help to address a management information deficit as it will allow service delivery to be measured.

And recommends in general that:

1. The HSE should establish benchmarks to underpin decision making on the allocation of human resources
2. Decisions on resource allocation should be based primarily on activity levels with incentives being put in place to improve performance
3. Data collected through the HealthStat system should inform allocation decisions and be made more readily available to key stakeholders including Oireachtas Committees
4. All major health development projects should be planned on the basis of whole life cost and should not be signed off until agreement is in place on all inputs including human resource requirements.

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Chapter Three: The Consultants' Contract

3.1 INTRODUCTION

Medical consultants working in acute public hospitals are employed under the terms of a national common contract of employment which was adopted in 1997. As outlined in Chapter One, consultants' salaries amounted to €350 million in 2006. In addition, substantial pension entitlements also accrue under the terms of the contract. The common contract covered the number of hours to be worked by consultants each week and the extent to which they could treat private patients. It also had provision for their co-operation in the development of clinical audit and providing for increased managerial involvement. An agreement on a replacement contract has been reached, however the details on the number of existing consultants who will move to the new contract is not available at the time of writing.

The Comptroller and Auditor General reviewed the operation of the 1997 contract to establish the extent to which the terms of the contract were being delivered. His examination found that key provisions of the 1997 contract were poorly defined or were unclear. As a result, hospital managers had difficulties when they tried to implement those provisions.

In particular, the examination found:

- there was a significant difference of interpretation between the health service employers and the consultants on the agreed number of hours to be worked. The employers claimed the contract provided for consultants to work a 39 hour week, but the consultants contended that only 33 hours were actually contracted
- most hospital managers did not collect the kind of information that would allow them to satisfy themselves that consultants were discharging their contracted commitments. In particular, hospital managements were unable to prove that the 9 to 12 hours per week provided for consultants to undertake research, training and management activities were, in fact, spent on those activities
- that the 20% overall limit for treatment of private patients in public hospitals was not adhered to and that private patients' occupation of beds in public hospitals exceeded 20% in all three categories of clinical activity - elective, emergency and day cases. The level of monitoring and management of consultants' private practice levels has been insufficient to ensure the designated limits are observed
- there was limited follow-through on the obligations placed on consultants to participate in clinical audit. Clinical audit and clinical risk management remained underdeveloped and, where audits were carried out, they were not part of planned prioritised programmes and results were generally not reported to hospital managements or shared with other hospitals.

The Committee was concerned that in the period 1997 to date there had been no real attempt to monitor compliance with the terms of the consultants' contract. It considers this was a key responsibility of management. In particular the Committee was concerned that the number of hours service to be

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delivered under the contract remained in dispute for ten years. It noted that, other things being equal, the impact of this was that the salary payments made by health boards to purchase 39 hours of consultants' time per week in circumstances where consultants believed and worked on the basis that official hours of service were 33 hours per week. While recognising that some consultants may in fact have worked in excess of their contracted hours, there should be clarity on the time commitments of consultants so as to ensure that no non-effective expenditure is incurred.

The Committee will recommend that, with the introduction of the new contract, commitments be monitored and enforced in order to ensure that value is received for the salaries paid to consultants.

Under the terms of the new agreement reached with the consultants, not all consultants will transfer to the new contract. In such circumstances, the Committee will recommend that the terms of the 1997 contract be strictly enforced so that these consultants are seen to deliver services in accordance with their commitments.

The Committee noted that, as with the 1997 agreement, the current agreement envisages considerable process change. Progress in introducing clinical audit and the involvement of consultants in management have been disappointing over the past ten years. The Committee welcomes the establishment of a contract implementation group under the chairmanship of Mark Connaughton SC, who chaired the consultants' contract negotiations and will recommend that the group report at six monthly intervals to the Minister for Health and Children on the implementation of the terms of the new contract.

Finally the Committee noted that movement to a more measured and consultant driven service will not necessarily be cost neutral. There is therefore a need for ongoing evaluation to ensure that the benefits are in line with the costs.

3.2 THE LEVEL OF PRIVATE PRACTICE IN PUBLIC HOSPITALS

The Committee was informed, in a letter dated 20th May from the HSE, that information reports on the level of private practice in public hospitals were anonymised and it could only supply information on a specialty by specialty basis at national level. The information thus supplied confirmed the findings of the Comptroller and Auditor General that the 80:20 split was not managed and was significantly breached in most specialties.

The fact that details of private practice on a consultant by consultant basis cannot be made available to the Dáil or cannot be published is a major flaw in the management of the consultants' contract and it is an issue that the Committee will want rectified under the proposed new contract.

On the substantive issue of ensuring that the contract terms were adhered to, there was a clear failure on the part of the HSE, the Health Boards and ultimately the Department of Health and Children to put systems in place to monitor and control the contracts with the result that services and resources were

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diverted away from the treatment of public patients towards private patients.

The Committee noted the assurances of both the Department and the HSE that the new consultants' contracts will have specific measurement systems that which will address the flaws in the 1997 contract. The Committee intends to review the situation in 2009.

3.3 FINDINGS AND RECOMMENDATIONS

The Committee finds specifically that:

1. There was a failure on the part of the HSE, the old health boards and ultimately the Department of Health and Children to put adequate management systems in place to ensure that the 1997 consultants contract was operated as intended
2. The 80:20 split for private practice in public hospitals was largely ignored ultimately to the detriment of public patients
3. An agreement entered into with consultants whereby data was anonymised prior to publication, and thus rendered meaningless, facilitated the non management of hospital consultants.

And recommends in general that:

1. The new consultants' contract should provide absolute transparency on the time commitment to public hospital duty of consultant staff: these commitments should be monitored and enforced in order to ensure that value is received for the salaries paid to consultants
2. The HSE should introduce a stringent monitoring regime of public and private caseloads in hospitals and data on the level of private practice in public hospitals should be published on a consultant by consultant basis
3. The terms of the 1997 contract should be strictly enforced in respect of those consultants who do not transfer to the new contract so that these consultants are seen to deliver services in accordance with their commitments
4. The contract implementation group, that will oversee the change process, should provide six monthly progress reports to the Minister for Health and Children.

Chapter Four:

Charges for Private Beds in Public Hospitals

4.1 INTRODUCTION

The figures available to the Committee in respect of 2006 indicate that 24.4% of the beds in public hospitals were occupied by private patients. As outlined in paragraph 1.2 of this report, current expenditure in 2006 amounted to €12 billion and the Committee was informed that approximately €4 billion of this was allocated to hospitals. The Committee noted that the amount recouped from health insurers to meet the costs of private patients amounted to €146 million and was concerned that the HSE was only recovering 7% of the operating budgets of hospitals to cover approximately 25% of its inpatient activities.

4.2 ECONOMIC COST OF A BED IN A PUBLIC HOSPITALS

The amount levied by public hospitals on health insurers to cover the cost of a private bed is set by the Minister for Health and Children. In 2006, that rate was set at €758. However, it was not evident to the Committee that this figure had a direct connection to the cost of a bed. The Committee was informed that, while it was difficult to get an average cost per bed night, the policy of the Department was to charge the economic cost and that recent increases in charges had substantially bridged the gap between the cost and the rate charged.

The Committee is not satisfied, based on the information supplied, that an appropriate charge is being levied in respect of private beds and that the HSE and the Department should seek full recovery of costs. Information is available on the costs of every diagnosis treated within hospitals (under 660 different headings) and an analysis of these costs and the average length of hospitalisation per procedure would give a cost per day and this is the figure that should be charged for the private bed in a public hospital. Where the economic charge is discounted to take account of the fact that the patient has paid PRSI and/or has an entitlement to a bed as a public patient, the amount of the discount should be highlighted.

The amount paid by the National Treatment Purchase Fund per procedure to private hospitals (90% of NTPF funded procedures are carried out in private hospitals) should also be analysed to establish a benchmark cost. As the NTPF negotiates prices with potential providers for particular quantums of service and procedures with private hospitals, the amount it is charged should contain the economic (marginal) cost plus an element of profit. The Committee will continue to review this issue and will recommend that the Department of Health and Children seek expert advice and conduct a cost analysis of the economic charge when establishing the figure to be charged for a private bed in a public hospital.

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Finally, the HSE should report annually in its appropriation account on the cost of private treatment and patient maintenance in public hospitals highlighting the amount recovered from the private insurance industry.

4.1 FINDINGS AND RECOMMENDATIONS

The Committee finds specifically that:

1. While 25% of the patient discharges in public hospitals were accounted for by private patients, private health insurance companies did not bear 25% of the cost of hospital beds
2. It is the policy of the Department of Health and Children to charge the economic cost of a private bed in a public hospital: this has not been achieved
3. The National Treatment Purchase Fund, since its establishment in 2002, has paid for treatment for over 100,000 patients: approximately 90% of these patients received their treatment in a private hospital and it therefore has a benchmark of costs that have been determined by market forces.

And recommends in general that:

1. The Department of Health and Children should conduct a cost analysis on the economic cost of keeping a private patient in a public hospital bed
2. The full charge of treating and maintaining a patient in a private bed in a public hospital should be calculated and any amount discounted from that figure, due the fact that the patient would have had underlying entitlements as a public patient, should be highlighted
3. The HSE should report annually in its appropriation account on the cost of private treatment and patient maintenance in public hospitals, highlighting the amount recovered from the private health insurance industry.

Chapter Five:
Utilisation of Assets and Facilities

5.1 INTRODUCTION

The HSE, on 22nd April 2008, supplied the Committee with a list containing 2632 properties which are in its ownership and, in relation to these, the Committee raised a number of issues about investment, usage and disposal. At the same time as properties were lying idle, the HSE was paying €153 million annually in rent, with some leases being for up to 25 years in duration. The issue of hospital equipment laying idle following purchase was also raised with the HSE in the context of efficient use of resources. The Committee is anxious that a proper asset register is maintained and that all assets are fully utilised.

In particular, the Committee raised concerns about the following:

1. the three community houses purchased in Castlepollard
2. the site at Our Lady's Hospital in Cork
3. the CAT scanner in Mallow General Hospital
4. the overall property management policy of the HSE

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5. re-investment of proceeds from the sale of lands in mental health services.

5.2 THREE COMMUNITY HOUSES IN CASTLEPOLLARD

Under Government mental health policy dating back to the 1980s and outlined most recently in 2006 in *A Vision for Change*, it was proposed that people with special needs would be moved from institutional care to care in the community. A number of residents at St Peter's Centre in Castlepollard remain in an inappropriate, old-fashioned institution despite the fact that the health board purchased three community houses in the Castlepollard area in 2001 and these houses have lain idle for the past seven years. The health board paid €640,000 for the three houses which now require refurbishment costing €150,000.

When the Committee investigated this issue, it found that the Midland Health Board entered into an arrangement to purchase the houses without a plan for moving the residents from St Peter's and without a budget to do so. The HSE estimate that the move will cost €1.5 million and are now finalising plans to staff the three houses by moving staff currently employed in institutions. The Committee noted that, while the taxpayer ended up paying for something that was not used for seven years, the real losers in this case were the residents of St Peter's whose quality of life would have been greatly improved over the past seven years had they been moved to community houses where they would have enjoyed a more independent lifestyle.

5.3 OUR LADY'S HOSPITAL IN CORK

A number of buildings in the complex of Our Lady's Hospital in the northside of Cork City, some of which are listed buildings, have lain idle for a number of years and some have been vandalised. The Committee noted that the security at the complex was inadequate and sought a report from the HSE on its proposals for this site.

Having examined the issue, the Committee was informed that a decision to dispose of the unused buildings in the complex was taken as far back as 2004, but that, in order to recover maximum value for the sale of the properties, a new access route was needed and this has since been provided by the City Council as part of the development of affordable housing on a nearby site. A decision on whether to sell the assets or to seek to exchange the property with another property which would be used to develop a mental health facility is still under consideration. The Committee is concerned that the example of Our Lady's Hospital indicates a failure on the part of the HSE to properly manage its asset portfolio.

5.4 CAT SCANNER AT MALLOW GENERAL HOSPITAL

The HSE purchased a CAT scanner for Mallow General Hospital in 2006 at a cost of €1.5 million. It approved the appointment of two radiographers and held a competition to fill the posts. However, because the hospital is over-quota in terms of its staffing numbers, an embargo has been placed on the filling of the two radiographer posts with the result that the CAT scanner has remained unused. In the meantime, patients have to

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be taken by ambulance from Mallow to Cork to receive treatment.
Having examined the issue, the Committee was informed that Mallow had 76 beds and 251 staff, which was sufficient staffing complement to manage a CAT scanner. The policy of the HSE is to try and align staffing with workload and for that reason it would not now agree to the appointment of the two radiographers.

While the issue of the alignment of staff to workload was dealt with in chapter 2, the fact remains that a scanner to the value of €1.5 million was purchased and a competition was held to appoint radiographers and it appears that these two decisions were taken in a vacuum, when issues relating to staffing levels should have been sorted out before this expenditure was sanctioned. The patients who have to travel to Cork by ambulance are the people who are being failed by the system.

5.5 PROPERTY MANAGEMENT BY THE HSE

As outlined in the introduction, the Committee was given a list of 2,632 properties that are either owned by or leased to the HSE. However, it does not have a detailed inventory on the use and occupancy of these properties. The accounts of the HSE also show that it is spending €155 million in rent and rates.

The Committee has concerns that

(i) property is laying idle while the HSE is renting property
(ii) full market value is not being realised when property is being disposed of
(iii) the property needs of the HSE are planned to increase significantly in the context of the development of community care teams throughout the country: this expansion may happen without taking account of the property already in the ownership of the HSE given the absence of a national property register.

The HSE is developing a national database of its entire property assets and the Committee will review this in 2009 to see where rentals can be rationalised and where property can be disposed so as to release equity for re-investment in other facilities. The other issue which the Committee will want to review is the price received for property as public lands tend not to be zoned for commercial use, but rather for amenity or community use which impacts negatively on market price. It is the view of the Committee that the HSE should interact with local authorities on the designation of land banks as part of its disposal of assets policy.

5.6 FINDINGS AND RECOMMENDATIONS

The Committee finds specifically that:

1. €640,000 was spent in 2001 on three houses in Castlepollard that have not been used since their purchase. In the meantime, the patients for which they were intended remained in institutional care
2. Buildings, including listed buildings, at Our Lady's Hospital in Cork have lain idle for some years and have been vandalised
3. A CAT scanner at Mallow General Hospital, which cost €1.5 million, has remained unused since 2006
4. The HSE does not have a national data base of its entire property portfolio.

And recommends in general that:

1. All future purchases of property and utilities should be accompanied by appropriate business plans and issues such as staffing requirements should be finalised before contracts to purchase are agreed
2. Where facilities have been purchased, the HSE should deploy them as quickly as possible to ensure value from the investment. Instances noted by the Committee where delays occurred include
   - failure to utilise, since 2001, three community houses in Castlepollard by setting a deadline for moving patients from St Peters' Centre
   - failure to secure agreement with Mallow General Hospital on the operation of the CAT scanner purchased in 2006
3. In order to ensure that property for the primary care teams and other initiatives is sourced rationally, the national database of HSE property should be finalised as soon as possible, but not later than the end of 2008
4. The HSE should adopt a property management policy which seeks to achieve maximum utilisation of its property portfolio and disposal of surplus properties in a timely manner.

Chapter Six:

Financial Management and Financial Accounts

6.1 INTRODUCTION

This chapter deals with the way finance accounts of the HSE are presented and the financial management systems in place to manage day to day expenditure, with regard to the overspend in 2007. The Committee found it difficult to extract information from the accounts, given that there is not the degree of breakdown in the administrative subheads that is normally associated with the vote structure. On the more important issue of financial management, the Committee raised concerns about the way funding, which was earmarked for specific projects in the budget, could be moved from an area to meet cost overruns in another area. The Committee also investigated the reason an over-spend in 2007 led to a curtailment of services and sought assurances that such an event would not re-occur.

6.2 FINANCIAL ACCOUNTS

The HSE prepares two sets of financial accounts, namely an appropriation account which records how the HSE spent the money voted by the Dáil in the year and the conventional financial statements. The former is compiled on a cash basis and presents expenditure by subhead while the latter is compiled on an accruals basis and contains a much greater level of detail on expenditure.

In the normal appropriation account, administration costs are broken down into seven distinct subheads, where for example the amount spent on salaries is

separated from the amount spent on travel and subsistence. That normal breakdown is not available in the HSE appropriation account, which made it difficult to examine expenditure in specific areas. The cause of this difficulty dates back to the establishment of the HSE when it took over eight different financial management systems of the old health boards and where it was recognised that the old vote format was an unsatisfactory way of producing information.

The HSE did explain that it was revising the subhead formats to a basis that would be more appropriate for an organisation like the HSE and for those who are examining the accounts. However, that move was dependant on the creation of a single integrated financial system. The Committee was also informed that the 2008 estimates contained a revised vote structure for the HSE which will break down the allocation of resources by care groups. The Committee will review progress on the way financial information is presented by the HSE and looks forward to examining more transparent accounts in the future. The key issue for the Committee is that the accounts should allow analysis of expenditure so as to make comparisons between the budget and the out-turn and also to be able to detect trends in expenditure on a year on year basis.

6.3 MOVEMENT OF FUNDS WITHIN THE VOTE

A cornerstone of public sector financial management is that money is voted by the Dáil based on detailed estimates broken down to specific areas of expenditure on services. While Departments have certain scope to allocate funds within the vote to different areas, this generally requires the approval of the Department of Finance and in exceptional circumstances, the relevant Minister may require the approval of the Dáil by way of a supplementary estimate. The Committee examined this issue in the context of dedicated funds being used by the HSE for other services in order to balance its budget.

The Committee noted that specific funding was earmarked for the development of palliative care services and some of this money was used by the HSE to meet cost overruns in other areas. The HSE justified this diversion of funding as it had to cope with demand led increases in services such as emergency hospital admissions. The Committee was concerned that money for palliative care could be diverted without recourse to the Department of Finance. The Department explained that the HSE vote has only three subheads, dealing with administration, services and capital spending. The vast majority of the budget was in the subhead dealing with services. The Department could only get involved where monies were being transferred between the subheads and, therefore, it was restricted in the way it exercised financial control of spending. The Committee finds this situation unsatisfactory from a control point of view. This example also highlights the fact that the ultimate losers were the many old people who required dedicated palliative care which was not provided.

The Committee noted that, in 2006, a part of the budget dedicated for capital projects was diverted to meet day to day running costs. This diversion of funding was approved by the Department of Finance. One of the

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problems this creates is that there is not only a knock-on delay in meeting commitments on particular projects, but new projects coming on stream in the following years will be delayed as the original projects remain at the top of the priority list for the new funding. Examples cited to the Committee where promised projects had been delayed included the new dedicated oncology unit at the Waterford Regional Hospital, which was due to commence in 2008, and the outpatient facility for cystic fibrosis patients which was to open in Beaumont Hospital in September 2008. While the delays in the two projects cited is not directly attributable to the re-designation of capital funds in 2006, their delay can be attributed to the fact that 2006 projects which did not proceed would have had to get priority in the 2007 capital budget.

The Committee is assured that this freedom to move large sums of money within the vote of the HSE will be restricted from 2008 as development funds cannot be used for other purposes without the specific sanction of the Department of Finance.

6.4 INVESTMENT IN MENTAL HEALTH FACILITIES

A key aspect of *A Vision for Change*, which was published in 2006, was that the proceeds from the sale of lands and buildings would be reinvested in the mental health sector. Some of the largest and most valuable properties in the HSE property portfolio are old psychiatric hospitals which will become available for sale as mental services become increasingly community based. The Committee had concerns that this was not happening and inquired as to the amounts that had arisen from the sale of properties that is currently ring-fenced for re-investment in mental health services.

It was informed that a sum of €2 million had been returned to the exchequer as extra receipts since *A Vision for Change* and that sums of €36 million in 2005 and €19.6 million in 2006 had also been returned to the Exchequer as extra receipts, giving total receipts of €57.6 million. There is a commitment to reinvest €36 million of the figure surrendered to date in mental health services and a submission had been made by the HSE in 2008 to the Department of Finance to utilise this fund. The Committee noted the delay in drawing up plans for monies that became available in 2005 and will keep this issue under review especially as properties like old psychiatric hospitals become available for disposal in the years ahead.

6.5 GENERAL FINANCIAL CONTROL PROCEDURES WITHIN THE HSE

In September 2007, the HSE was forced to introduce a range of measures in order to keep within its budget. This let to suspension of services, including services to disability organisations, hospital ward closures and a staff embargo. The Committee examined this issue as it was concerned at the ability of the HSE to monitor expenditure and manage its budget given the need for drastic corrective action eight months into the financial year. In particular the Committee wanted to establish why corrective action was not taken earlier in the year.

The HSE informed the Committee of the reasons for the over-run, which related in the main to overruns in demand led schemes such as the drug payment schemes and also

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increases in the level of activity in hospitals. The HSE did outline also that hospital activity had exceeded its service level agreements. The Committee accepts that the HSE did not wait until September 2007 to take corrective action and that it appears that appropriate monitoring measures are now in place. The Committee will, at future examinations of the HSE accounts, review the way the HSE manages its budget so that the financial outturn remains within budget provisions.

6.6 FINDINGS AND RECOMMENDATIONS

The Committee finds specifically that:

1. The structure of the 2006 appropriation account of the HSE was in a format that made it difficult to analyse
2. The absence of an integrated financial management system hinders the way the HSE can present its appropriation accounts
3. Because of the structure of the HSE vote, the Department of Finance was restricted in the way it exercised financial control of the €12.3 billion expenditure of the HSE
4. HSE funding for new developments, compensation schemes and capital are not ring fenced and the application of this funding to meet over-runs on the core budget makes it difficult to judge financial performance on the current basis of accounting
5. Because of a cost over-run in 2007, the HSE had to curtail services and introduce an embargo on recruitment
6. A plan to utilise the €38 million that was ring-fenced from the sale of hospital property for investment in mental health services has not yet been agreed between the HSE and the Department of Finance.

And recommends specifically that

1. The HSE should develop an integrated financial management system
2. For transparency, new developments, compensation schemes and capital spending should be ring-fenced within the vote of the HSE
3. A note to the Appropriation Account should set out, by subhead, the amount included in the provision for new developments and the amount utilised in the year for these developments as well as an explanation of the main delayed initiatives
4. Plans for the utilisation of the €38million that is ring-fenced for mental health services should be agreed between the HSE and the Department of Finance in 2008.

Chapter Seven: The Operation of the National Treatment Purchase Fund

7.1 INTRODUCTION

The National Treatment Purchase Fund (NTPF) was established in 2002. Its role is to purchase treatment, primarily from private hospitals, so as to reduce the length of time public patients have to wait for surgery. In 2007, 22,069 public patients received their in-patient hospital treatment under this initiative. The NTPF is also responsible for collating the national waiting list data for inpatient and day case hospital treatment. In addition the NTPF arrange outpatient appointments for public patients to see a hospital consultant in a number of selected specialties.

The Committee examined the follow issues relating to the operation of the NTPF:

(i) the purchase of treatment by public hospitals
(ii) danger of self-referral by consultants
(iii) benchmarking of costs of treatment
(iv) NTPF waiting lists and the disparities between parts of the country
(v) remit of the NTPF.

7.2 PURCHASE OF TREATMENT BY PUBLIC HOSPITALS

The Committee was informed that the NTPF can purchase a maximum of 10% of its overall capacity from the public hospital system where this does not adversely impact on core services. The Committee has a concern, having regard to the fact that private bed designations in public hospitals has exceeded the 20% threshold, that public hospitals are using the treatment fund as an extra source of revenue from the State. The data supplied to the Committee shows that 22,069 patients were treated under the initiative in 2007 and of those 1,774 (8%) were treated in public hospitals. The Committee will ask that the Department and the National Hospitals Office of the HSE review this issue to ensure that NTPF funds are not used as a revenue generating exercise by public hospitals.

7.3 SELF-REFERRAL BY CONSULTANTS

Consultants in charge of public patients can in certain circumstances end up treating the same patient under the NTPF scheme. The Committee has concerns that consultants could cherry-pick patients off their list as a way of generating extra revenue from their private practice using the NTPF. The Committee was informed that in 2007 the total number of cases where a consultant treated a patient in a private hospital where that patient had been on that consultant's waiting list in a public hospital was 3,802 or 11.6% of the total cases treated. 19% of consultants treated a patient in a private hospital who had originally been on their public waiting list.

The Committee accept that in exceptional circumstances [relating to acceptable and safe treatment of patients] the same consultant should treat the patient under

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the NTPF. However, the Committee considers that the rate at which this happens is unusually high. This issue, when account is taken of the practice of hospitals to allow more than 20 % of its beds to be designated for private use, leads the Committee to conclude that greater vigilance is required to prevent any abuse of the system as there is a danger that long public waiting lists are being sustained because consultants are not doing the amount of public work that they are required to do and that some consultants are deriving greater benefit where the public patients are referred on through the NTPF to private hospitals. That benefit is direct when the consultant ends up treating his/her own patient in the private hospital.

7.4 BENCHMARKING OF TREATMENT COSTS

Chapter 4 of this report dealt with the concern that public hospitals are not charging an economic rate for private beds in hospitals. The Committee examined the way procedures were purchased from private hospitals by the NTPF. It noted that the amount paid by the NTPF for any procedure is not disclosed as it is deemed commercially sensitive and disclosure could damage the State's bargaining power. The average cost of in-patient care in 2007 was €4,267. The Comptroller and Auditor General has access to this information and is able to assess the amount being paid for procedures. The Committee finds it difficult to analyse this issue given that data on the amount paid by health insurers to hospitals is not available and it is difficult therefore to determine whether the State is getting value for money in respect of NTPF expenditure. The Comptroller and Auditor General has agreed to do a review of these areas as part of his ongoing audit of the NTPF expenditure. The Committee will review this issue and would like to see benchmark costs developed so that those actual costs can be subjected to greater analysis.

7.5 WAITING LISTS

The NTPF has responsibility for compiling hospital waiting lists, and when the Committee heard evidence from the CEO of the Fund in May 2008, he supplied the hospital waiting lists as part of this evidence. While overall numbers on waiting lists have declined, the Committee noted regional disparities which indicate that some public hospitals are not engaging actively with the NTPF in order to clear those who are on waiting lists over 12 months. The Committee is also concerned that there are a large number of patients on public waiting lists over two years and that hospitals are not placing an emphasis on clearing those patients from their waiting lists.

While patients on waiting lists for more than three months can contact the NTPF and are dealt with in a short space of time, the way the NTPF implements its mandate is to give priority to those who are 12 months or more on public hospital waiting lists. The information available to the Committee on waiting lists is outlined below.

Waiting Lists as at 1 May 2008

Time Period	Number of Patients
Over 3 months	16,166
Over 6 months	8,628
Over 12 months	2,155
2 to 3 years	305
3 years plus	110

The Committee noted that the North West region of Donegal and Sligo fared poorest in terms of the numbers waiting more than 2 years for treatment. The explanation given by the NTPF is that hospitals such as Letterkenny General Hospital and Sligo General Hospital are not referring enough of their patients to the fund to clear their waiting lists. The Committee will ask that the HSE review this to ensure that hospitals are not rewarded by getting larger budgets based on the level of their waiting lists. The Committee also notes that those on waiting lists for two or more years may have refused elective treatment and will ask that they be either removed from the list or treated by hospitals. The Committee noted that the National Hospitals Office is to be asked to get involved so as to ascertain the reason hospitals fail to co-operate fully with the NTPF and will review the situation in 2009.

7.6 REMIT OF THE NATIONAL TREATMENT PURCHASE FUND

As part of its examination the Committee reviewed the powers available to the NTPF to fulfil its mandate. The NTPF has a service level agreement with the Department of Health and Children and it then seeks agreement with hospitals around the country on the number of patients that will be treated under the fund. From the evidence given to the Committee, it is clear that the co-operation of hospitals in dealing with waiting lists is a key issue and, while the NTPF has certain purchasing power which it can use to buy treatment in a private hospital for public patients, the process can be hindered and indeed stopped where there is a failure on the part of the public hospital to co-operate with the NTPF. The NTPF is dependant on the voluntary co-operation of hospitals and does not have power or authority to manage the waiting lists that are compiled based on the returns made by hospitals.

Given the resources available to public hospitals and the supplementary resource that is the budget of the NTPF, there is no valid reason why 2,155 patients are waiting longer than 12 months for treatment. The Committee will propose that the NTPF be given a stronger mandate in dealing with public hospitals so as to ensure that patients do not have to wait longer than 12 months for treatment.

7.7 FINDINGS AND RECOMMENDATIONS

The Committee finds specifically that

1. Public hospitals had spare capacity in 2007 which allowed them to treat 1774 patients under the National Treatment Purchase Fund
2. 3,802 patients were treated under the National Treatment Purchase Fund by the consultant who had that patient on his/her public waiting list
3. 2,155 patients are on public hospital waiting lists for more than twelve months which is unacceptable given the availability of the National Treatment Purchase Fund to augment the services of public hospitals
4. The remit of the National Treatment Purchase Fund in dealing with public hospitals is weak
5. Hospitals that do not co-operate with the National Treatment Purchase Fund end up with longer waiting lists.

And recommends specifically that

1. The HSE should review the incidence of public hospitals using the National Treatment Purchase Fund to pay for treatment in the same hospitals and be in a position to certify that those hospitals had the spare capacity to allow them undertake this work
2. The HSE should conduct an audit of cases where consultants were paid under the National Treatment Purchase Fund for treatment to a patient that was on that consultant's public waiting list so as to be able to certify that public funds were applied is the most cost effective manner possible
3. The National Treatment Purchase Fund should establish a benchmark of costs, which the Comptroller and Auditor General can use to assess whether value for money is being obtained by the National Treatment Purchase Fund in the amount paid for treatments
4. Public hospitals should be given a direction to clear those longer than 12 months on their waiting lists and the HSE should impose sanctions against those hospitals that fail to do so
5. The Department of Health and Children should review the powers available to the National Treatment Purchase Fund with a view to strengthening its authority viz a vis public hospitals.

Chapter Eight:

Cost of Drugs under the General Medical Scheme

8.1 INTRODUCTION

The control of the cost of drugs prescribed by GPs under the General Medical Scheme (GMS) has been an issue for the health sector dating back many years. In 2006 the accounts of the HSE show payments for pharmaceutical services amounted to €1.654 billion (including drugs cost, wholesale delivery and pharmacist fees). Controlling the cost of drugs can be achieved where generic drugs are substituted for more highly priced branded drugs and where such practices do not endanger patient care. A scheme entitled the Indicative Drugs Target Scheme (IDTS) was introduced in January 1993 where savings identified would result in investment by the State in GP services. That scheme was suspended in January 2006 and a review of IDTS, carried out by the HSE concluded that it was "no longer achieving its stated objective to promote rationale cost-effective prescribing by GPs". The Committee is anxious that measures which would reduce the cost of drugs be also pursued and raised two specific concerns with the HSE in this regard.

8.2 OVER-PRESCRIBING OF DRUGS

At present there is no incentive to prevent the prescribing or dispensing of drugs that are not needed by patients. Under the present arrangements each sale of a

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prescribed drug is charged under the GMS and community drugs schemes and, if anything, the more drugs that are prescribed and dispensed, the greater the level of profit that is generated. This can lead to a situation where patients end up with stockpiles of drugs in their home that are not used. Money is therefore being wasted. The HSE accept that there is a need to create an incentive whereby pharmacists are paid per prescription and where payment is made irrespective of whether drugs are given to the patient. Pharmacists would be encouraged under such a scheme to ascertain whether the patient had a sufficient quantity of drugs before deciding whether to make further drugs available. The Committee recommends that discussions be initiated as part of the revised GP contract and with the Irish Pharmacy Union (IPU) about the introduction of such an incentive, which has potential to make significant savings under the scheme.

8.3 INCENTIVE SCHEMES BY PHARMACEUTICAL COMPANIES

The second area reviewed by the Committee related to prescription practices by GPs. The HSE accept that there is a need to educate GPs on prescription habits, particularly in relation to antibiotics, and outlined to the Committee the steps being taken to tackle this issue. The Committee also raised concerns about the incentives that pharmaceutical companies use in order to encourage GPs to prescribe their drug brands. The Committee was informed that while governance rules are applied in relation to HSE employees, they do not apply to other medical professionals. The Committee was informed that this issue was a matter for the Medical Council which has guidelines on GPs' commercial relationships and that it was conducting a review of its ethical guidelines. The Committee is concerned that the incentives used by the pharmaceutical companies have the capacity to undermine any proposals that the HSE has of reducing the cost of prescribed drugs and will therefore recommend that this issue be addressed by the Medical Council. The Committee is of the view that the current arrangements are open to abuse and that comprehensive new guidelines are required covering all aspects of the relationship between doctors and the pharmaceutical industry. These new guidelines should be accompanied by a strict enforcement regime and should carry strong penalties where the guidelines are breached.

8.4 FINDINGS AND RECOMMENDATIONS

The Committee finds specifically that:

1. The Indicative Drugs Target Scheme, which was designed to reduce the cost of the drugs prescription scheme, was suspended in 2006 as it was no longer meeting its stated objectives
2. There is a risk of waste where drugs are given to patients where the patient already has a supply of these drugs
3. The HSE is embarking on an educational programme with GPs that will address the issue of over-prescribing of drugs, specifically antibiotics
4. The incentives offered by pharmaceutical companies to GPs to prescribe specific branded drugs have the capacity to undermine any proposals that the HSE has to reduce the cost of prescription drugs
5. The ethical guidelines of the Medical

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Council on GPs commercial relationships do not cover such issues as the amount of personal travel that doctors should accept from pharmaceutical companies.

And recommends specifically that

1. The Department of Health and the HSE should initiate discussions with the Irish Pharmacy Union (IPU) and with the Irish Medical Organisation (IMO) on introducing incentives that will prevent the prescribing and dispensing of drugs that are not required and which will reduce the incidence of "over-prescribing" especially in the area of antibiotics
2. Ethical guidelines, which include new systems of enforcement and penalties, should be introduced by the Medical Council on all contacts between GPs and the pharmaceutical industry.

Chapter Nine:

Summary of Findings and Recommendations

The Committee of Public Accounts, having examined expenditure and value for money aspects of expenditure by the health sector, finds as follows:

EFFECTIVE DEPLOYMENT OF RESOURCES AND THE NEED FOR PERFORMANCE INDICATORS

1. The HSE has not developed systems which allow staff to be matched with activity levels
2. The absence of staffing level benchmarks may have contributed to the delay in the provision of much needed services such as at the newly developed A & E unit at the Mercy Hospital Cork
3. The HealthStat initiative outlined in paragraph 2.3 may help to address a management information deficit as it will allow service delivery to be measured.

THE CONSULTANTS' CONTRACT

4. There was a failure on the part of the HSE, the old health boards and ultimately the Department of Health and Children to put adequate management systems in place to ensure that the 1997 consultants' contract was operated as intended
5. The 80:20 split for private practice in public hospitals was largely ignored ultimately to the detriment of public patients
6. An agreement entered into with consultants whereby data was anonymised prior to publication, and thus rendered meaningless, facilitated the non management of hospital consultants.

CHARGES FOR PRIVATE BEDS IN PUBLIC HOSPITALS

7. While 25% of the patient discharges in public hospitals were accounted for by private patients, private health insurance companies did not bear 25% of the cost of hospital beds
8. It is the policy of the Department of Health and Children to charge the economic cost of a private bed in a public hospital:

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this has not been achieved

9. The National Treatment Purchase Fund, since its establishment in 2002, has paid for treatment for over 100,000 patients. Approximately 90% of these patients received their treatment in a private hospital and it therefore has a benchmark of costs that have been determined by market forces.

UTILISATION OF ASSETS AND FACILITIES

10. €640,000 was spent in 2001 on three houses in Castlepollard that have not been used since their purchase. In the meantime, the patients for which they were intended remained in institutional care
11. Buildings, including listed buildings, at Our Lady's Hospital in Cork have lain idle for some years and have been vandalised
12. A CAT scanner at Mallow General Hospital, which cost €1.5 million, has remained unused since 2006
13. The HSE does not have a national data base of its entire property portfolio.

FINANCIAL MANAGEMENT AND FINANCIAL ACCOUNTS

14. The structure of the 2006 appropriation account of the HSE was in a format that made it difficult to analyse
15. The absence of an integrated financial management system hinders the way the HSE can present its approriation accounts
16. Because of the structure of the HSE vote, the Department of Finance was restricted in the way it exercised financial control of the €12.3 billion expenditure of the HSE
17. HSE funding for new developments, compensation schemes and capital are not ring fenced and the application of this funding to meet over-runs on the core budget makes it difficult to judge financial performance on the current basis of accounting
18. Because of a cost over-run in 2007, the HSE had to curtail services and introduce an embargo on recruitment
19. A plan to utilise the €38 million that was ring-fenced from the sale of hospital property for investment in mental health services has not yet been agreed between the HSE and the Department of Finance.

THE OPERATION OF THE NATIONAL TREATMENT PURCHASE FUND

20. Public hospitals had spare capacity in 2007 which allowed them to treat 1774 patients under the National Treatment Purchase Fund
21. 3,802 patients were treated under the National Treatment Purchase Fund by the consultant who had that patient on his/her public waiting list
22. 2,155 patients are on public hospital waiting lists for more than twelve months which is unacceptable given the availability of the National Treatment Purchase Fund to augment the services of public hospitals
23. The remit of the National Treatment Purchase Fund in dealing with public hospitals is weak
24. Hospitals that do not co-operate with the National Treatment Purchase Fund end up with longer waiting lists.

COST OF DRUGS UNDER THE GMS SCHEME

25. The Indicative Drugs Target Scheme, which was designed to reduce the cost

of the drugs prescription scheme, was suspended in 2006 as it was no longer meeting its stated objectives

26. There is a risk of waste where drugs are given to patients where the patient already has a supply of these drugs
27. The HSE is embarking on an educational programme with GPs that will address the issue of over-prescribing of drugs, specifically antibiotics
28. The incentives offered by pharmaceutical companies to GPs to prescribe specific branded drugs have the capacity to undermine any proposals that the HSE has to reduce the cost of prescription drugs
29. The ethical guidelines of the Medical Council on GPs commercial relationships do not cover such issues as the amount of personal travel that doctors should accept from pharmaceutical companies.

The Committee recommends in general that:

EFFECTIVE DEPLOYMENT OF RESOURCES AND THE NEED FOR PERFORMANCE INDICATORS

1. The HSE establish benchmarks to underpin decision making on the allocation of human resources
2. Decisions on resource allocation should be based primarily on activity levels with incentives being put in place to improve performance
3. Data collected through the HealthStat system should inform allocation decisions and be made more readily available to key stakeholders including Oireachtas Committees
4. All major health development projects should be planned on the basis of whole life cost and should not be signed off until agreement is in place on all inputs including human resource requirements.

THE CONSULTANTS CONTRACT

5. The new consultants' contract should provide absolute transparency on the time commitment to public hospital duty of consultant staff: these commitments should be monitored and enforced in order to ensure that value is received for the salaries paid to consultants
6. The HSE should introduce a stringent monitoring regime of public and private caseloads in hospitals and data on the level of private practice in public hospitals should be published on a consultant by consultant basis
7. The terms of the 1997 contract should be strictly enforced in respect of those consultants who do not transfer to the new contract so that these consultants are seen to deliver services in accordance with their commitments
8. A national process should be put in place to monitor and verify the changes envisaged in the new contract.

CHARGES FOR PRIVATE BEDS IN PUBLIC HOSPITALS

9. The Department of Health and Children should conduct a cost analysis on the economic cost of keeping a private patient in a public hospital bed
10. The full charge of treating and maintaining a patient in a private bed in a public hospital should be calculated and any amount discounted from that figure, due the fact that the patient would have had underlying

entitlements as a public patient, should be highlighted

11. The HSE should report annually in its appropriation account on the cost of private treatment and patient maintenance in public hospitals, highlighting the amount recovered from the private health insurance industry.

UTILISATION OF ASSETS AND FACILITIES

12. All future purchases of property and utilities should be accompanied by appropriate business plans and issues such as staffing requirements should be finalised before contracts to purchase are agreed
13. Where facilities have been purchased, the HSE should deploy them as quickly as possible to ensure value from the investment. Instances noted by the Committee where delays occurred include
    – failure to utilise, since 2001, three community houses in Castlepollard by setting a deadline for moving patients from St Peter's Centre
    – failure to secure agreement with Mallow General Hospital on the operation of the CAT scanner purchased in 2006
14. In order to ensure that property for the primary care teams and other initiatives is sourced rationally, the national database of HSE property should be finalised as soon as possible, but not later than the end of 2008
15. The HSE should adopt a property management policy which seeks to achieve maximum utilisation of its property portfolio and disposal of surplus properties in a timely manner.

FINANCIAL MANAGEMENT AND FINANCIAL ACCOUNTS

16. The HSE should develop an integrated financial management system
17. For transparency, new developments, compensation schemes and capital spending should be ring-fenced within the vote of the HSE
18. A note to the Appropriation Account should set out, by subhead, the amount included in the provision for new developments and the amount utilised in the year for these developments as well as an explanation of the main delayed initiatives
19. Plans for the utilisation of the €38million that is ring-fenced for mental health services should be agreed between the HSE and the Department of Finance in 2008.

THE OPERATION OF THE NATIONAL TREATMENT PURCHASE FUND

20. The HSE should review the incidence of public hospitals using the National Treatment Purchase Fund to pay for treatment in the same hospitals and be in a position to certify that those hospitals had the spare capacity to allow them undertake this work
21. The HSE should conduct an audit of cases where consultants were paid under the National Treatment Purchase Fund for treatment to a patient that was on that consultant's public waiting list so as to be able to certify that public funds were applied is the most cost effective manner possible
22. The National Treatment Purchase Fund should establish a benchmark of costs, which the Comptroller and Auditor

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General can use to assess whether value for money is being obtained by the National Treatment Purchase Fund in the amount paid for treatments

23. Public hospitals should be given a direction to clear those longer than 12 months on their waiting lists and the HSE should impose sanctions against those hospitals who fail to do so
24. The Department of Health and Children should review the powers available to the National Treatment Purchase Fund with a view to strengthening its authority viz a vis public hospitals.

THE COST OF DRUGS UNDER THE GMS SCHEME

25. The Department of Health and the HSE should initiate discussions with the Irish Pharmacy Union (IPU) and with the Irish Medical Organisation (IMO) on introducing incentives that will prevent the prescribing and dispensing of drugs that are not required and which will reduce the incidence of "over-prescribing" especially in the area of antibiotics
26. Ethical guidelines, which include new systems of enforcement and penalties, should be introduced by the Medical Council on all contacts between GPs and the pharmaceutical industry.

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Orders of Reference of the Committee of Public Accounts[1]

(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;

(b) power to take oral and written evidence as defined in Standing Order 81(1);

(c) power to appoint sub-Committees as defined in Standing Order 81(3);

(d) power to engage consultants as defined in Standing Order 81(8); and

(e) power to travel as defined in Standing Order 81(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 twelve members, none of whom shall be a member of the Government or a Minister of State, and four 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.

(1) The Orders of Reference of the Committee of Public Accounts are set out in Standing Order 158 of Dáil Éireann

Public Accounts Committee
30th Dáil

Allen, Bernard (FG)
(Chairman)

Broughan, Thomas
(Lab)

Clune, Deirdre
(FG)

Collins, Niall
(FF)

Cuffe, Ciarán
(GP)

Fleming, Seán
(FF)

Kenneally, Brendan
(FF)

McCormack,
Padraic (FG)

O'Brien, Darragh (FF)
(Vice-Chairman)

O'Keeffe, Edward
(FF)

O'Keeffe, Jim
(FG)

Shortall, Róisín
(Lab)

** Deputy Edward O'Keeffe replaced Deputy John Curran who was appointed Minister of State on 13th May, 2008*

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