



Dáil Éireann

An Coiste um Chuntais Phoiblí

**An Ceathrú Tuarascáil Eatramhach do 2003
(Éisteachtaí an Choiste, Deireadh Fómhair 2004 go dtí Iúil
2005)**

**An Roinn Sláinte agus Leanaí; Ospidéal Beaumont; Bord
Sláinte an Iarthuaiscirt; Bord Sláinte an Deiscirt; agus an
Roinn Gnóthaí Sóisialacha agus Teaghlaigh**

Feabhra, 2006

Dáil Éireann

Committee of Public Accounts

**Fourth Interim Report for 2003
(Committee hearings October 2004 to July 2005)**

**[Department of Health and Children; Beaumont Hospital;
North Western Health Board; Southern Health Board; and
Department of Social and Family Affairs]**

February, 2006

(Prn. A6/0114)



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February, 2006

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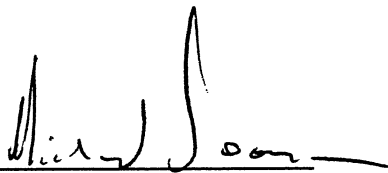
Chairman's Preface

This interim report of the Committee of Public Accounts continues the process of the Committee, which commenced last year, of reporting periodically on a thematic basis. The subject matter of this report details the Committee's consideration of various Reports of the Comptroller and Auditor General that examined a number of bodies, namely, the Department of Health and Children; the accounts of Beaumont Hospital; the accounts of some health boards and the Health Service Executive and the Department of Social and Family Affairs.

The Committee's most recent interim report examined the Office of the Revenue Commissioners, the National Treasury Management Agency and the National Pensions Reserve Fund Commission. The Committee will, during the course of 2006, publish further interim thematic reports on a number of issues, namely, Department of Education and Science; Civil Service Commission, Department of the Environment, Heritage and Local Government and Department of Finance; Department of Communications, Marine and Natural Resources, Office of Public Works, Department of Transport and the Department of Enterprise, Trade and Employment; An Garda Síochána, Department of Defence and the Department of Foreign Affairs; and Department of Agriculture and Food and Teagasc.

As Chairman, I want to thank the relevant State agencies for their co-operation in making the compilation of this report possible. I also want to compliment the members of the Committee for their diligent work throughout the year.

The Committee recommends this report to Dáil Éireann.

A handwritten signature in black ink, appearing to read 'Michael Noonan', with a horizontal line underneath it.

Michael Noonan, T.D.,
Chairman.

February, 2006

Members of the Committee of Public Accounts

FIANNA FÁIL

Seán Ardagh T.D.	Dublin South-Central
John Curran T.D.	Dublin Mid-West
John Dennehy T.D.	Cork South-Central
Seán Fleming T.D.	Laois-Offaly
John McGuinness T.D. (<i>Vice-Chairman</i>)	Carlow-Kilkenny
Michael Smith T.D. ⁴	Tipperary North

FINE GAEL

John Deasy T.D. ²	Waterford
Tom Hayes T.D. ³	Tipperary South
Michael Noonan T.D. ¹ (<i>Chairman</i>)	Limerick East

LABOUR

Joan Burton T.D. ⁵	Dublin West
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GREEN PARTY

Dan Boyle T.D.	Cork South-Central
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SOCIALIST PARTY

Joe Higgins T.D.	Dublin West
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1 Deputy Michael Noonan replaced Deputy Padraic McCormack by order of the House on 18th June, 2003.

2 Deputy John Deasy replaced Deputy Paul Connaughton by order of the House on 20th October, 2004.

3 Deputy Tom Hayes replaced Deputy John Perry by order of the House on 20th October, 2004.

Deputy Michael Noonan elected as new Chairman on 21st October 2004.

4 Deputy Michael Smith replaced Deputy Batt O’Keeffe by order of the House on 16th November, 2004

5 Deputy Joan Burton replaced Deputy Pat Rabbitte by order of the house on 29th November, 2005.

Orders of Reference of the Committee of Public Accounts

156. (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.

The Report

1. Special Report No. 7 – Health Sector Audits

1 Proceedings of the Committee

1.1. The Committee heard evidence from Mr. Michael Scanlan, Secretary General, Department of Health and Children; from Mr Kevin Kelly, Interim Chief Executive, Health Service Executive and his officials; and from the Comptroller and Auditor General on 28 April 2005.

2 The Background

2.1. The establishment of the Health Service Executive is a significant milestone in the development of the health services. The restructuring is intended to enable the health service to develop so that it can provide more effectively and efficiently for the needs of patients in the context of a unitary national delivery system. The special sector report was produced as the HSE was being established.

2.2. The report outlines the way in which expenditure in the health sector has increased and the matters upon which it has been spent. Pay and pay related expenditure account for the bulk of the increase, reflecting general and special pay rises together with an expansion in the numbers employed. Apart from advances in service developments and greater expenditure on clinical supplies, the rising cost of the general medical services scheme has been a major contributory factor in increased expenditure.

3 The Accountability Issues

3.1. The accountability questions examined by the Committee were:

- Staff numbers in the health sector
- Level of nursing staff
- Cost cutting
- Acquisition of property without approved funding
- Patients' private accounts

4 Examination of the Questions

Staff numbers in the health sector

4.1. In April 2005 the number of established staff positions in the HSE was 97,255. At the end of 2004 there was 1,400 staff in excess of the approved ceiling. The original determination of the ceiling in 2002 did not take account of vacancies in the system or posts that had been approved but not filled because of recruitment lags.

4.2. Prior to 2005, controls over staff levels and monitoring systems were ineffective. There were problems getting accurate information. The old system relied on an annual census which took at least six months after that census to get figures. There is now a quarterly census system in place managed by the HSE and the information is received within ten weeks of the end of the quarter.

4.3. 75% of staff are frontline, for example, health and social professionals, dental and patient care professionals. It can be difficult to examine management and administration as a block. The Department is trying to focus on increasing the numbers involved in frontline delivery as services are developed. Strict adherence to a numbers policy will therefore result in a cut back of non-frontline staff. The Department has identified the groups where both increases and decreases of the numbers employed can occur.

4.4. A reliance on agency staff is an uneconomic way of using resources. From 2003 to 2004, an additional 2,200 staff was employed in the health sector. Of those, 389 were in the administrative group, with almost two thirds of these engaged in direct patient services, supporting consultants, on wards, in laboratories, and one third employed in direct administration services.

Level of Nursing Staff

4.5. The change in the training programme from two years to a three year degree course has led to a temporary gap in the numbers of nurses qualifying. There is a project underway to recruit and retain nurses from Ireland and abroad. Since 1998 the number of training places increased from 968 to 1,640 and the number of student nurses in training went up by more than 70%. In 2005, more than €85 million was being spent on undergraduate nursing training.

4.6. A significant number of nurses have come from abroad to work in Ireland. Their contribution to the service has been significant. Obstacles that might hinder recruitment of significant numbers of nurses are being pursued with the Department of Health and Children and other Departments. Nursing is the visible frontline delivery service. There are moves to change the jobs done by different groups in the health service. In other countries, nurses undertake traditional medical duties and healthcare assistants undertake some traditional nursing duties. With the support of the Department of Finance a skills programme is underway. This will train healthcare assistant staff to undertake duties currently undertaken by nurses and will release nurses to provide direct care to patients in the system.

4.7. The cost of an agency nurse is typically 1.8 to 1.9 times that of a staff nurse. This is because the hourly rate may be greater, there is an agency fee and VAT payable.

Cost cutting

4.8. The merging of 11 health boards into a national system, offered the potential for significant savings. This will take time because the State has given an undertaking that there will be no involuntary redundancies. For 2005, the HSE aimed to deliver savings of €200 million. As a national agency the HSE has buying power with suppliers and is using that power to negotiate better value for money.

4.9. The immediate concern on the €200 million savings is the need to stay within the staff cap. Most of the problems in the health service have resulted from the false economies achieved by cuts in the early 1980s. The health service has the same number of beds as in the 1980s for a population that has increased in size. In the attempt to achieve the 1,400 staff reductions and €200 million expenditure cuts, these types of false economies will need to be avoided. In terms of rolling out the national service plan with the HSE, it is accepted that service planning and performance reporting arrangements must improve.

4.10. In 2004 a number of brand new facilities were sitting idle because revenue and staff resources were unavailable to have them opened. More and more facilities are now being opened and an inventory of all capital resources within the HSE is being made. In terms of local involvement, the focus is on local health offices on the primary community side. The aim, where possible, is to lessen patients' journeys when they attend for treatment.

Acquisition of property without approved funding

4.11. The way in which area boards of the Eastern Regional Health Authority and the North Western Health Board went about procuring new headquarters was highlighted. Two main issues arise with regard to the area boards. First, capital expenditure was incurred on new headquarters without having a permanent source of funding in place. Second, a failure to properly plan accommodation requirements in Bray, Co. Wicklow led to a €3.4 million fit-out of a building which was only partly used for four years before being vacated.

4.12. In 2001, the CEOs of the health boards understood that they had sanction to spend €2.4 billion over the relevant period of the NDP. Part of the understanding arose from the fact that, in July 2001, the Department said that it would visit all of the boards to validate their projects. After visiting just one board, this approach was abandoned. The boards had received a letter stating that, if they did not spend the indicative funding, it would be allocated to high-spending health boards. The individual projects were described as "approvable projects" and would add to the asset base that allows services to be delivered. When the NDP was published, there was an effort made to ensure that people would be able to spend the money allocated and in particular draw down the necessary funding from Brussels.

4.13. On the other hand, the NDP was an investment plan with indicative funding levels separate from the actual decisions on funding, which, at that stage, were made annually for capital projects as part of the Estimates process. It was entirely separate from the existing approval system that had operated up to then. The Department had no explanation for the apparent confusion. It maintains that expectations had been raised, and while there was a need to plan capital spending multi-annually, there had been no change whatsoever in the capital approval process or in the expenditure allocation process.

4.14. The NDP was multi-annual indicative. There is now a multi-annual capital investment framework where allocations are approved by Government and published each year in the Budget, with provisions to pre-commit money. Up to 85% of the allocation for 2005 may be pre-committed for the following year, so it is possible to now get involved with certainty in making plans and giving financial commitments. In 2001, the problem was that the annual expenditure allocation system put pressure on boards to spend.

4.15. The HSE has its own Vote, so as regards indicative funding it has clarity up-front in terms of the actual cash available in any one year. The capital investment framework is a five year plan that sets out the level of real cash available for the HSE over the life of the plan. The HSE can plan with some certainty around the funding that is available. The process for getting approval has also changed. The board adopted and approved the projects to be funded from the capital budget for 2005. Those projects will be linked to a specific cash amount.

4.16. A significant amount of property throughout the country was in the ownership of the health boards, including houses and land not in use, and land attached to hospitals that will

not be needed even when developments expected in the next 20 years are taken into consideration. The HSE, was in 2005, doing a complete inventory with a view to examining the results.

Patients' private accounts

4.17. A previous report of the C&AG pinpointed weaknesses in the way in which patients' private property is administered and accounted for by the various health boards. Most of the money held in private property accounts belongs to long-stay patients in hospitals and nursing homes. A working group made a number of recommendations, some of which had not been implemented on the grounds that current arrangements were regarded as operating satisfactorily.

4.18. In the Southern Health Board a working group was set up in 1997 to examine patients' private property accounts. The group recommended that interest earned on patients' property should be used to administer the patients' private property fund. A substantial amount was involved because from 1999 to 2001, the administration charge came to €1.7 million and interest received was €2.5 million. Eight of the ten boards switched to that approach.

4.19. The Committee observed that as pensions are not being retained and persons are getting rebates as a result of the deductions made in the nursing homes issue, the quantum of patient property is about to increase. Since the HSE began to make *ex gratia* payments, the amount increased by about €15 million in the first few months of 2005. Since the start of 2005 definitive legal advice has been sought on what the exact approach should be. The HSE is also in discussion with the NTMA and the central treasury on how the funds may be jointly invested. The Committee stressed the urgency of the need to have the matter sorted out and suggested that advice should be sought from the Office of the Attorney General.

5 Adoption of Reports

5.1. The Committee disposed of Special Report 7 on Health Sector Audits.

6 Findings and recommendations

The Committee of Public Accounts

Finds specifically that:

1. The effective management of the high staff complement and the resources consumed by staffing in the health sector represent one of the most important challenges to the HSE in delivering value for money. The freeze on numbers introduced in 2002 did not take adequate account of vacant positions and delays in recruitment processes at that time.
2. The number of nursing training places increased from 968 to 1,640 between 1998 and 2005. The investment in nursing graduate training in 2005 was €85 million. Nurses recruited from abroad in recent years have made a significant contribution to the health sector. The moves to redefine the duties allocated to nursing and healthcare assistant staff are positive steps to improve frontline service delivery in the health sector.

3. The cost of an agency nurse is up to 1.9 times the cost of a staff nurse. The dependence on agency nurses needs to be managed and is expected to reduce due to higher numbers coming through the nursing degree programme.
4. The rationalisation of health sector structures, involving the creation of the HSE should lead to improvements in efficiency and cost effectiveness. For 2005, the HSE aimed to deliver savings of €200 million without affecting existing levels of service.
5. There was a serious communications failure in 2001 between the Department and the health boards which led to unauthorised financial capital commitments by health boards.
6. The quantum of patients' private property accounts is increasing and there is an urgent need for the HSE to clarify the legal position and to standardise its policy for the administration of the accounts across all regions of the country.

And recommends in general that:

1. Effective arrangements should be put in place to monitor and control staffing numbers in the health sector.
2. The HSE needs to properly classify staff to facilitate the development of norms for the appropriate ratio of administrative and management staff to frontline staff.
3. The contribution made by staff in direct support of frontline staff in the delivery of services should be taken into account when determining their classification.
4. The numbers of contract and agency staff employed should be kept under close review at all times in view of the significant cost implications of employing these categories of staff.
5. A standard procedure, taking account of both legal advice and best practice, should be put in place on the administration of patients' private property accounts.
6. There should be clear guidance on the requirements for the approval of capital projects in the health sector.

2. Department of Health and Children – Vote 33; and Chapter 12.1

1 Proceedings of the Committee

1.1 The Committee heard evidence from Mr. Michael Scanlan, Secretary General, Department of Health and Children and his officials; from officials of the Health Service Executive; from officials of the Department of Finance; and from the Comptroller and Auditor General on 26 May 2005.

2 The Background

2.1. In addition to the Vote of the Department the Committee considered two issues that had been reported upon in the Report of the C&AG in 2001. The first was the difficulties associated with trying to recover approximately €8.5 million from doctors who had been overpaid capitation and related payments under the GMS scheme, arising from the failure by health boards to delete invalid medical card records from the system at the appropriate time. The second issue was the refund of moneys to persons affected by the delay in putting the drugs payment scheme on a proper legal footing.

3 The Accountability Issues

3.1. The accountability issues examined were:

- Patient statistics and staff numbers
- Perception of value for money in the Health Service
- Uncommissioned capital projects

4 Examination of the Issues

Patient statistics and staff numbers

4.1. Total discharges in 2004 amounted to 1,040,181, an increase of 33% since 1997 and of just over 2% on the 2003 figure. There is a significant difference in terms of the increase between inpatients and day cases. With regard to the cumulative increase since 1997, the corresponding figure for day cases is an increase of 91%, while the inpatient figure is 7.4%. The 2004 figure for casualty unit attendances is 1,240,241, a 2.4% increase on the 2003 figure - the cumulative increase since 1997 is 2.2%. For outpatient department attendance, the 2004 figure was 2.368 million, compared to a figure of 1.9 million for 1996. The totality of people who came through hospitals under the headings of inpatient, day, casualty and outpatient attendances in 2004 worked out at 4,615,000.

4.2. There is no comparable figure in Europe for such an enormous percentage of the population seeking hospital treatment in a particular year. In statistical terms, about a quarter of the population avails of hospital facilities. A significant increase in day hospital throughput is welcome as it enables people to return to their daily business quickly.

4.3. In the period 1997 to 2004, staff numbers increased from 67,895 to 98,723, an increase of 30,828 or 45%. They are categorised as medical, nursing, health and social care professionals, general support and other patient care and management administration. In

broad terms, management administration accounts for just under a quarter of the total increase of nearly 31,000. General support and other patient client care accounts for another quarter. The other half is accounted for by medical, nursing and health and social care.

4.4. From another perspective, medical staff numbers have increased by just over 40% since 1997. Nursing has risen by 25%. There is a problem with the statistics for the other two categories - health and social care and general support - because a group of child care workers moved from one to the other. In that sense, the figures are somewhat skewed. One is very high, at 115% and the other is very low, at 37%. Management administration staff numbers increased by approximately 80%. Just over two thirds of management administration personnel are involved in direct patient services, which leaves approximately one third who are involved in core administration. The more recent figures show that the large increase in numbers was concentrated in the period 1997 to 2002. Instead of a 45% increase over the entire period, there was an increase of 3.4% in the period from 2002 to 2004.

4.5. The Committee noted that in 1997, the analysis was that if adequate resources and staff were available to deliver the service, the problems in the health service would be solved. It was also recognised, however, that day-to-day problems and crisis management would remain. The health service had been run down in the late 1980s but picked up in the 1990s. In 1997, the health budget was €3.2 billion. In 2005, current expenditure was €9.2 billion. Given that the total number employed in Ireland is approximately 1.9 million and 100,000 are employed in the public health service, one person out of every 19 at work is working in the public health service.

Perception of value for money in the Health Service

4.6. The Committee expressed concern that the public perception is that there is poor value for money in the health sector. This must be put in the context of the point that the spend has trebled and the number of staff has increased to 100,000. In addition, the new HSE does not have its full complement of key people. The manner in which that money has been spent bears examination in the wider public domain. A significant proportion of the money invested in the health sector has gone towards staff payments due to increasing staff numbers and the rate of inflation in pay costs. There is insufficient data in this regard but it is accepted that health inflation is higher than general inflation. New drugs that come on the market tend to be more expensive. However, they are also usually more effective and it is understandable that the health service should try to produce and deliver the most effective care.

4.7. One of the problems with the health service has been its failure to communicate the message of the good service that is provided. There are independent surveys which point to good patient satisfaction with the service received. These difficulties are not unique to the health service. Patients generally rate the health service highly. There are problems in regard to access and this is sometimes reflected in the conditions in accident and emergency units. The consensus among the experts is that what is required is sustained investment in health to make up for the earlier under-investment identified by members. There is a similar situation in regard to infrastructure which cannot be brought up to international standards through the allocation of significant funding over a period of two or three years. Funding for the health service must be forthcoming at a sustained level.

Uncommissioned capital projects

4.8. Capital projects with a value of €400 million were built without having been commissioned due to the fact that sufficient resources were not allocated to the current budget to staff those facilities. There is now a suggestion that the Department of Health and Children will proceed differently in the future and will only provide a building when it is sure that it can commission and staff it immediately. The idea of the vacant building as a type of monument to the inefficiency of the system with no staff or output and no access for potential patients would, therefore, be a thing of the past. The process by which projects are selected in the health service at the very initial stages of capital planning involves the requirement to balance need, cost and impact.

4.9. One of the problems is a lack of joined-up government - the quandary of having funds in the capital budget and not having enough funds in the current budget to commission the facilities. Either the Department will simply carry out replacement work from its capital budget, or it will return capital funds to the Exchequer at the end of the year.

5 Adoption of Reports

5.1. The Committee noted Vote 33 of the 2003 Appropriation Accounts and disposed of Chapter 12.1 of the 2003 Annual Report of the Comptroller and Auditor General.

6 Findings and recommendations

The Committee of Public Accounts

Finds specifically that:

1. The outputs of the health service in terms of inpatient discharges, day patients, outpatients, casualty and accident and emergency services have increased significantly since 1997. In total, in excess of 4.6 million persons were treated in hospitals in 2004.
2. Overall staff numbers employed in the health sector have increased from 67,895 in 1997 to 98,723 in 2004, an increase of 45%. Most of the increase occurred in the period 1997 to 2002. In 2005, one person in every 19 in employment, worked in the health sector. The overall budget for health has increased from €3.2 billion in 1997 to €9.8 billion in 2005 (current €3.035 billion to € 9.203 billion; and capital €166 million to €584 million).
3. Whilst it is recognised that access to both accident and emergency services and to consultants is often quite difficult the level of service provided to those admitted to the system is good.
4. There have been problems in recent years with the matching of proposals for capital investment with the provision of a sufficient budget for the running costs of new facilities.

And recommends in general that:

1. The Department and the HSE should develop, on a national basis, a comprehensive set of health indicators against which outcomes can be compared.
2. The Department should consult with the HSE and other relevant agencies to improve the quality of reporting the effectiveness of different medical practices and procedures across all areas within the health sector.
3. Further efforts should be made by the Department to achieve a satisfactory and fair outcome in the matter of recovering overpayments made to GPs on foot of invalid medical cards.
4. The commissioning and running costs should be factored into the decision making process on health capital projects.

3. Beaumont Hospital – 2000, 2001 and 2002 Accounts

1 Proceedings of the Committee

1.1. The Committee heard evidence from Mr. Liam Duffy, Chief Executive, Beaumont Hospital and his officials; and from the Comptroller and Auditor General on 20 January 2005.

2 The Background

2.1. Accounts for three years, 2000 to 2002 inclusive, were considered by the Committee.

3 The Accountability Issues

3.1. The accountability issues examined by the Committee were:

- Procurement irregularities
- Beaumont Hospital Car Park
- Charges to consultants

4 Examination of the issues

Procurement Irregularities

4.1. The 2001 accounts contained a supplement to the audit report which drew attention to control weaknesses in the hospital's procurement procedures, particularly in the Technical Services Department (TSD) in the years 1999-2001. Normal tendering procedures were not adhered to and required approvals were not sought before either undertaking work or awarding contracts. The Committee was informed that there had been improper use of service request authorisations (SRAs) in the technical services department to avoid putting a significant amount of work out to tender. The SRAs were only meant to be used for urgent work. It has always been the policy of Beaumont Hospital that there should be open and transparent tendering. This was corrected in 2003 and clear procedures are now in place.

4.2. Evidence produced by the internal auditor, who examined these matters in great detail in 2001, suggested that quotations from non-existent companies were produced in order to portray a situation where there was a competition when in fact no competition had taken place. The work was then given to one particular firm. It was irregular also to pay for work that had not been carried out or carried out unsatisfactorily or to have work done and then construct a fictional tender competition afterwards. This matter was referred to the Garda Síochána. The Committee sought details of what had been put in place to ensure that the problem would not re-occur. The Hospital now advertises publicly for contractors without specifying the jobs on offer. It interviews contractors and places them on a short list from which a panel is created. Contractors are rotated over a two year period after which a new panel is drawn up.

4.3. Senior management had identified in 1999 that SRAs were being used to divide jobs into smaller lots which circumvented the procurement process. The disciplinary processes within the Hospital were used to deal with that situation. There were no indications of

problems prior to 1999. The Head of TSD had been recruited in 1998 and resigned in 2001. It was subsequently established that the qualifications presented at the time of his application for the post were fraudulent.

Beaumont Hospital Car Park

4.4. The car park agreement provided that if people did not use the multi-storey car park, the hospital was obliged to put in place systems that protected the staff car parks and stopped illegal parking on the campus. The car park operator was able to fine the hospital for illegal car parking. The total amount in fines levied was about €1.2 million between the start of the scheme and the time the imposition of fines ended. That amount effectively equalled the Hospital's share of car park income for that period. A new arrangement which was worked out gave the hospital €100,000 each year, access to car parking spaces and ended the fines.

4.5. There was a possibility of a tax liability on the income from the car park. The car park provides two streams of income. One is called the first rent, the rent that accrues to the hospital, while the other is a payment into a sinking fund which will be passed over to the operator in 2011. It was originally intended that the hospital would receive the rents and that it would not have a tax liability on them. A wholly owned special purpose company was set up to develop the car park which continued to receive the rents, although the Board was advised that it was receiving them as an agent for the hospital. The tax authorities deemed that the company was receiving them in its own right, not as an agent for the hospital, and accordingly that they were taxable in the hands of the company because it did not have a tax exempt status similar to the hospital. The hospital is contesting the view that the car park company was acting as an agent of the hospital in the collection of rents a point being used to appeal to the Appeals Commissioners. A sum of €792,000 is involved. The intention is that the subsidiary will be wound up as soon as these issues are completed. The Committee noted that because two public bodies are involved the tax issue had no overall financial effect to the taxpayer. The Committee, however, was concerned that the State would not have to suffer adversely from any legal proceedings that might ensue.

Charges to consultants

4.6. The Hospital has had difficulties in collecting charges for laboratory services provided for patients of the Beaumont Private Clinic which is located on the grounds of the hospital. These difficulties are part of a wider problem regarding the charging for services by public hospitals to private medical institutions and their patients. The hospital has a number of properties from which it gets rental income, some on a commercial basis while others, including the private clinic, are rented on a preferential basis. There are more than 100 consultants involved in the private clinic. The private clinic pays €12,000 per annum in rent to the hospital (€120 per consultant). According to Hospital estimates, the value of the laboratory services provided for the 100 consultants in the private clinic in terms of services rendered to their patients in the years 2002 or 2003 was €260,000 per annum, which represents approximately 2% of the laboratory costs. This is effectively, €2,600 per consultant per annum on average. Some consultants in certain specialties would use the service more than others. Part of the consultants' common contract is to allocate 30% of their time for private patients and 70% for public patients. That is reflected in the throughput of private patients in the organisation. There are no measures for monitoring consultants' performance in any public hospital.

4.7. The C&AG had reported, as far back as 1997, that the hospital was not invoicing the adjacent private clinic for tests and where it was making charges for laboratory services, these did not bear any relationship to the economic cost of supplying the services. It is estimated that €2.7 million in revenue from the Beaumont Private Clinic was forgone as a result of not being billed over a period from January 1998 and December 2002.

5 Adoption of Reports

5.1. The Committee disposed of the accounts for Beaumont Hospital for 2000, 2001 and 2002.

6 Findings and recommendations

The Committee of Public Accounts

Finds specifically that:

1. Deficiencies in procurement procedures were identified in the Technical Services Department. Following investigations by internal audit it was established that there had been a series of irregularities in that area of the hospital between 1999 and 2001.
2. The background check on the qualifications of a manager was not adequately performed by the hospital when he was appointed in 1998. The qualifications claimed were later found to be fraudulent.
3. The car park contract has been regularised and is operating as originally intended. The hospital is deriving an income in the region of €750,000 per year from the contract. The potential tax liability from income in the period 1999 to 2003 is unresolved. The hospital could incur significant legal liability to pursue a tax appeal.
4. The private clinic at the hospital pays approximately €120 per consultant (€12,000 in total) in rent for use of the hospital's laboratory facilities. The value of the laboratory facilities is estimated to be approximately €2,600 per consultant per year. Where the hospital does invoice for laboratory services, the amounts involved bear no relation to the economic cost of providing the services. It is estimated that the revenue forgone for the period 1998 to 2002 is about €2.7 million.

And recommends in general that:

1. The Internal Auditor should have the opportunity to report to the Board without the CEO being present.
2. Public sector organisations should automatically check the references and qualifications of applicants for all positions of authority.
3. The provision of support services, including laboratory services to private consultants, should be on a full cost arms length basis.

4. North Western Health Board – 2001 Accounts

1 Proceedings of the Committee

1.1. The Committee heard evidence from Mr. Pat Harvey, Chief Executive Officer, North Western Health Board; from officials of the Department of Health and Children; and from the Comptroller and Auditor General on 23 September 2004.

2 The Background

2.1. Two issues arose from the accounts for 2001 which merited public accountability, namely, the provision of new headquarters and the failure of accounting controls in the purchasing system.

3 Examination of the Issues

Acquisition of new Headquarters

3.1. In 1998, the buildings for the corporate function of the Board in Manorhamilton were inadequate. The Board decided on a new building on an adjoining site and, following a tender competition, a contract was placed in March 2001. The contract covered the construction, fitting out and commissioning of the building. The Board's staff moved in April and May 2003 and the final cost, including professional fees, was about €9.5 million.

3.2. The Board's aim was that the new headquarters building in Manorhamilton would be self-financing and would not compromise the capital development programme for patient services. It had a deliberate intention not to use the NDP funds for offices and reserved all of its capital funds for patient-related services. Money (up to €400,000 per year) previously paid out on rentals, travel and hotel accommodation for Board meetings would be used to pay off a mortgage on the offices. The farmland of St. Conal's Hospital in Letterkenny was sold to the IDA to accommodate the development of a business park. The Board earmarked the money received, approximately €3 million, and a further €500,000 received in respect of road widening for the complete refurbishment of the acute psychiatric unit in Letterkenny. In the interim, the money was used as a short term measure in a cashflow context but there was no intent to use it in the medium to longer term for that purpose.

3.3. The first contact with the Department of Health and Children was in July 2001 when the Board applied to the Department for the loan as was required under legislation. At that stage the tendering process was complete and contract documents had been agreed. The loan was not approved.

3.4. The Committee questioned the procedures followed at the time. An appraisal was carried out to calculate the amount that could be saved on rent. The Board then determined that it would easily cover a loan repayment. The Committee noted that it would normally be prudent to put the loans in place before embarking on projects and the Board accepted this point and that it should have liaised more with the Department in the early stages of the project. In this case, the health board went to tender and engaged a contractor, without loan approval. While the Department supported improvements in accommodation for the Board

the difficulty was that there was no avenue to seek loans once an NDP programme was in place as that is the system's vehicle for funding capital projects.

3.5. The Committee noted that the procedure pursued with regard to the initial project at a value of less than €1 million was correct in that the Board interviewed a number of architects, one of whom was selected. Following the receipt of a develop and control plan, it decided to provide a new building at a vastly increased cost. The health board should have gone through EU procurement procedures, realised the position it was in and readvertised the project. The board also breached EU procedures in the engagement of the design team.

3.6. The Committee acknowledged that the Board could have carried out this work through a rental-leasing route without engaging the contractor at more expense and less value for the taxpayer, and would not have to appear before it. The Board chose to take the capital construction route. While the Board admitted that it might have breached some procedures, it is satisfied that it got greater value for money by so doing.

3.7. The Committee often has the problem of criticising bureaucracy over delays in the implementation of decisions that are required to be made and for killing off initiative taken by chief executives. In this case public money was not spent badly as neither patient care nor services suffered. However, the Committee, as well as having to consider value for money, has a regulatory mandate and it considered that it was imprudent to embark on a major capital project without having the funding in place.

Failure of accounting controls in the purchasing system

3.8. During the final stages of audit a number of weaknesses in the area of purchasing controls became apparent. These weaknesses could have left the health board open to unauthorized purchases, duplicated payments and an overstatement of creditors and accruals. The auditors noted that the figure recorded as the value of goods received but not invoiced was not sound. The Board was aware of the likelihood of an overstatement having made a provision of €450,000 to allow for this but further checking established that the level of overstatement of year end creditors was more likely to be of the order of €2 million. The same problems beset the 2002 accounts with the result that the audit certificate for that year had to be similarly qualified. The Board admitted that the system was not operating as intended. Remedial action has been taken to ensure that there is no recurrence of the problem.

4 Adoption of Reports

4.1. The Committee disposed of the North Western Health Board Accounts for 2001.

5 Conclusions and Recommendations

The Committee of Public Accounts

Finds specifically that:

1. The Board engaged the contractor for its new headquarters before it had an approved source of funding.

2. Major problems arose within the accounting controls of the purchasing system.

And recommends in general that:

1. Commitments for major capital projects should not be made without having the necessary funding in place.
2. Improvements to the purchasing system in the North Western Area of the HSE need to be maintained.

5. Southern Health Board – 2002 Accounts

1 Proceedings of the Committee

1.1. The Committee heard evidence from Mr. Seán Hurley, Chief Executive Officer, Southern Health Board; from officials of the Department of Health and Children; and from the Comptroller and Auditor General on 23 September 2004.

2 The Background

2.1. The rules that govern public procurement operate at a number of levels — EU, national, sectoral and down to organisational level. The underlying principle in all cases is that competitive tendering should be used in procuring goods or services above certain thresholds unless there are compelling reasons for not doing so. The Board admits that it engaged a firm of management consultants without going through the proper tender procedure and that it should have availed of the derogation that would have been available by seeking the approval of the Government Contracts Committee or a provision for single tendering.

2.2. The Board is satisfied that over the years it achieved significant improvements in its management processes which help it to deliver better value for money. When the Minister set up the top level steering group, the equivalent of an ERHA was not established in Cork as it would have created unnecessary bureaucracy and would have required legislation. However, there was a difficulty in that no further mechanism was put in place to create one contracting entity with legal responsibility. It was up to the Board to deliver the health strategy.

3 The Accountability Issues

3.1. The accountability issues considered by the Committee were as follows:

- Use of management consultants since 1997
- PPP business case
- The acute hospitals strategy
- Capital deficit

4 Examination of the Issues

Use of Management Consultants since 1997

4.1. The Board first engaged a particular firm of consultants in 1997 without going through a tendering process. The firm was engaged based on its previous record and its methodology. The Board sought a firm of consultants to look at its business processes not to provide IT solutions. The overall aim was to make the health board more efficient. The first project involved developing a new senior management structure.

4.2. The Board developed its first corporate development plan for the period 1997 to 2000. It wanted to have a single, unified document and would monitor this monthly – something no other health board had ever prepared. The consultants helped devise the plan because the process of preparing the plan was considered more important than the end product.

4.3. The Board had established the first hospital and executive management committee at Cork University Hospital and wanted to establish a similar committee at Tralee General Hospital. The medical consultants from Tralee met the consultants from Cork and then approached the CEO to seek access to the firm of management consultants. They wanted to familiarise themselves with the terms of reference and to understand their management role. The CEO decided that involving the management consultants was a practical solution to get the medical consultants in Tralee involved in the management process.

PPP business case

4.4. When the NDP and the quality and fairness health strategy were published, they clearly signalled that the Government looked on the health sector as one where public private partnerships (PPPs), could be progressed. The management consulting firm had required the expertise abroad. The PPP in question was a pilot project.

4.5. While the Board was aware of the specific PPP unit within the Department of Finance, the involvement of management consultants was to construct the business case for a PPP project. The Department of Health and Children, at that stage, did not have PPP expertise. After the Board prepared an outline business case and submitted it to the Department of Health and Children, the Department created an internal PPP unit. This was a specific learning project for the Board as it was the first health board to prepare an outline business case and to make a submission to the Department of Health and Children and to the Department of Finance seeking funding, or approval, to proceed with a PPP project.

The Acute Hospitals Strategy

4.6. The context for the preparation of the acute hospital strategy in Cork was that in May 2000 the Minister met the chairman and CEO of the Board and representatives of the Mercy Hospital and the South Infirmary and outlined the intention, with effect from 1 January 2002, that the Board would become the single funding body for all agencies and that the two voluntary hospitals would be funded directly by the Board. One of the key recommendations was that the acute hospitals planning forum should be set up, representing all of the stakeholders, so that they could come together to prepare a strategy for the development of services in the city for the following ten years. At all times the consulting rates were compared to the market rates being quoted and the Board was satisfied with the competitiveness of the consultancy rates applied.

4.7. A number of years ago, the Health Boards Executive, HeBE, wanted work done by management consultants to develop a standard template for service planning. With the expertise built up, the Board bid for the work in an internal competition and won the tender at a very competitive price. By undertaking this project, the Board saved the Exchequer a considerable sum. Much of the money incurred on management consulting by the Board was greatly reduced because it then had the resources and the expertise to do this type of work.

4.8. The payments to the consultants were approved by means of executive decision. They were not listed as relating to specific projects. When the initial work from the top level steering group was submitted to the Minister, he approved all of it. The chairman, a professor of medicine at UCC, was obliged to send the report to the Minister who then asked that it be circulated to all health boards which discussed it. The Minister requested that the boards implement the various recommendations in the initial report.

4.9. The Committee noted that the consultants were charged with providing advice on management structures, corporate development plans, public private partnerships and the preparation of the acute hospital strategy for Cork. It felt that the consultants should have been aware that they should only have been appointed following a process of competitive tendering. When one appoints a consultant, one expects him or her to have a certain level of competence. The consultants should, therefore, have been aware of the rules applying to the process and should have brought to the attention of the Board the fact that it would be better for everyone involved if they were appointed in line with standard procedures.

Capital Deficit

4.10. The Committee noted that there was a capital deficit of €25 million in the 2002 Accounts. In the years 2000 to 2002, inclusive, the indicative budget for capital projects under the NDP was €119 million, but only €105 million was spent. Just less than €16 million of the deficit relates to NDP projects, all of which were approved by the Board. When the Board was notified of its allocation for the period 2001 to 2006, it submitted a schedule of projects amounting to the £240 million. Another element of the deficit was a €4 million loan which was approved by the Department of Finance and the Department of Health and Children for the purchase of new headquarters in Cork.

5 Adoption of Reports

5.1. The Committee disposed of the Southern Health Board accounts for 2002.

6 Conclusions and Recommendations

The Committee of Public Accounts

Finds specifically that:

1. The engagement of management consultants by the Board in the period since 1997 did not follow good procurement practice. The consultants were used in a variety of roles, including the provision of expertise (for developing PPP project proposals and developing the acute hospital strategy) that was otherwise not available to the Board.

And recommends in general that:

1. Public procurement rules should always be followed for the engagement of consultants and other external services by public bodies.

6. Department of Social and Family Affairs – Vote 40; and Chapters 13.1, 13.2 and 13.3

1 Proceedings of the Committee

1.1. The Committee heard evidence from Mr John Hynes, Secretary General, Department of Social and Family Affairs; and from the Comptroller and Auditor General on 27 January 2005.

2 The Background

Medical examinations

2.1. The sickness and disability payment schemes cater for a diverse group, ranging from people suffering from a short-term illness who may need nothing more than prompt payment of benefit for a couple of weeks until they return to work to those with significant disabilities who need additional supports over a longer period. The numbers in receipt of the main disability related payments have increased in the past ten years. The numbers claiming disability benefit for short-term illness increased from approximately 42,000 at the end of 1994 to approximately 59,000 at the end of 2004. The numbers claiming long-term disability payments have also increased from approximately 31,000 at the end of 1994 to approximately 73,000 at the end of 2004. In the same period the number of invalidity pension recipients increased from approximately 40,000 to approximately 56,000.

2.2. Reorganisation of work has enabled the assignment of additional resources to control work in the Longford office of the Department. The Department had a pilot initiative in 2003 to give priority to referring lower back pain cases for prompt medical examination. These cases represented 17% of all open disability benefit claims in 2002. The prompt call for examination resulted in both “early recovery” and “found capable” rates being higher than the average for short-term ailments. The success of this project suggested that early intervention might also have a positive impact on the duration of claims in respect of other identified high risk ailments.

Recorded overpayments

2.3. Recorded overpayments in 2003 totalled €39.4 million (2002: €29.13 million) against total welfare payments of more than €10 billion. About one third of these overpayments represented detected fraud. The scale of detected overpayments and fraud is related to the resources the Department can commit to control activity in any one year and to the effectiveness of the way in which those resources are applied. The increase in detections was due to a new unit established in 2003 for one parent family payments which increased the identified overpayments of this allowance from €1.6 million in 2002 to €8.4 million in 2003. This project was put in place after several projects undertaken at local level had identified the one parent family payment scheme as being high risk. In addition to work involved in the project, greater use is being made of information supplied by the Revenue Commissioners on people who have taken up employment and whose earnings exceed the limit for the payment. The Department has difficulty in recovering amounts overpaid. At the end of 2003 nearly €86 million was outstanding following the writing off of a total of €46 million in the previous five years.

Prosecution activity

2.4. In 2003, 355 criminal cases (2002: 205 cases) were forwarded to the Office of the Chief State Solicitor (CSSO). There were 210 criminal prosecutions finalised in court in 2003, of which, 186 involved social welfare recipients while 24 involved employers. The prosecution action was usually successful. Civil action is taken to pursue the recovery of material overpayments where it has been established that the recalcitrant debtor has sufficient means to discharge the debt.

3 The Accountability Issues

3.1 The accountability questions examined by the Committee were:

- Medical reviews
- Resources for medical assessment
- Overpayments
- Appeals
- Initiative on lower back pain
- Internal Audit

4 Examination of the Questions

Medical Reviews

4.1. Medical examination is an important element in the control arrangements for administering illness and disability schemes. There is a significant backlog of claimants generally awaiting medical examination. The backlog may contribute to a situation where many claims could be in payment which would otherwise have been terminated on medical examination. A review programme was put in place for all of the schemes depending on the length of time a person is in receipt of a benefit and the type of illness for which a person is certified. In practice it is found that when people are called for review many of them submit a final certificate. They do not actually turn up for the review because they have recovered and are able to return to work. The longer the notice that is given for an appointment in respect of a medical examination, the greater the chance that someone has recovered if he or she is suffering from short-term illness.

4.2. The medical reassessment process for Disability Allowance claimants had almost ceased. Only 16 claimants were reassessed in 2003 and all were found not to be qualified for the allowance. There is a greater likelihood that people will be found to be capable of working if they are examined. In practice, the persons concerned apply for and in the majority of cases obtain other benefits under the social welfare system.

Resources for Medical Assessment

4.3. The total cost of medical assessment is about €3.6 million per year. The Committee noted that there was an 8% reduction in the number of assessments in 2003 even though the actual number with insurable benefits for which the Department is catering has almost doubled since 1994. The number of assessments made is a function of the number of assessors available to carry out reviews. It has proved difficult to recruit people as medical assessors.

4.4. There are 21 medical assessors in the Department. These are doctors recruited to the medical assessment section of the Department. There is a chief medical adviser and a deputy medical adviser, to whom medical assessors report. For the 118,000 cases in 2003, of which roughly half were desk reviews and half full medical reviews, the medical assessors carried out all of the work. There were close to 72,000 cases for the long-term schemes (disability allowance and invalidity pension).

4.5. The Committee noted that 31,000 are waiting for assessments and felt that more could be done to improve the system. 11% of claimants failed to show up or gave insufficient notice of cancellation. The practice of reconfirming appointments closer to the date would be beneficial.

4.6. The Department spends in excess of €23 million per annum on fees to medical practitioners in respect of certificates and medical reports. The Committee was of the opinion that if the Department had a process of reviewing certificates signed by GPs, particularly against the opinions of the subsequent medical assessments, money would be saved.

Overpayments

4.7. The Committee noted that the cumulative figure for detected overpayments is quite small in comparison with the massive spending of the Department. Previously, where an overpayment case had been outstanding and where no activity had occurred on a case for three years the case was written out of the accounts. The current approach is that where cases go longer than three years and there has been no activity, the particular sections assess the likelihood of recovery in the near future and a decision on whether to write off is made. The fact that a case is written off does not mean that it would not be pursued in the future if an opportunity arose to do so.

4.8. The Department gets a constant monthly flow of information from the Revenue Commissioners about people who take up employment. This is checked against welfare records of people on payments. In that way, people who may not be entitled to the payment are identified. The Committee would like to see the potential benefit of an integrated system considered. At a cursory glance, the average overpayment is €1,000 per person. For people on social welfare, that causes considerable hardship and anxiety to repay. If they are not fraudulent, it would seem reasonable to expect that the two systems would be in communication with each other. No one should ever get to the situation where they have an overpayment against them in excess of €1,000. The Department advised that of the 40,000 people involved more than 50% would have overpayments of less than ten days' benefit.

Appeals

4.9. The Committee noted that 50% of decisions in medical appeal cases are upheld by the social welfare appeals officer, not withstanding that two medical examinations would have been carried out by the Department's medical referees. The Department's explanation for this is that there is a presentation of additional information to the social welfare appeals officer on the claimant's illness and disabilities. The Committee felt that there may be some cases where there is an inadequate assessment from the outset. The Committee recalled that there was a complaint in the Ombudsman's report in 2003 about summary decisions by deciding officers in the Department. They dismissed cases and decided that if the claimants wished to

lodge an appeal they could do so. The high success rate means that in respect of many cases the appeal officer's time is wasted going through the details of the case and claimants who have been disallowed payment must endure unnecessary hardship and have to seek assistance from a welfare officer in the health board. The Department argued that the high success rate on appeal indicated that the system is responsive.

Initiative on lower back pain

4.10. In 2002, 17% of claims for disability benefit were based on lower back pain. The Department selected 1,532 people in Dublin and Cork to be called for medical review. Before the people were called, 172 of the 1,532 sent in final certificates and walked away from the scheme. When the Department issued notification of examination, another 48% or 736 people sent in final certificates. A further 197 did not attend the medical examination. A total of 1,115 walked away from the scheme without pursuing their claim further. Only 154 of the original 1,532 qualified due to lower back pain - a further 127 qualified for reasons other than back pain - only 281 people maintained the allowance. An additional 2,775 cases were taken on in Dublin, Cork and Galway and the results for this group have been broadly similar to the first group.

4.11. The Committee was informed that 950 people found capable of work in the first few months of 2005 did not go back to work but went on to other schemes. This is an issue that should be investigated. Obviously, many of the people found capable of work may not be successful in getting employment and may end up back in the system. None of them were in the short term figures.

Internal Audit

4.12. The Department has an internal audit function in place headed by a professional accountant. The work of the internal audit is overseen by an Audit Committee that includes two external members. The unit carries out audits throughout the year on various schemes or local offices of the Department to ensure internal control procedures are being followed and it reports on its activities. These reports are reviewed by management in the Department and referred to the Audit Committee. A programme of audits to be carried out by the internal audit unit is decided upon at the beginning of each year.

4.13. The Department has set up a risk management unit, separate from the internal audit unit, to manage the risk assessment process and to co-ordinate it centrally. On a systematic basis the schemes and business areas throughout the Department carry out risk assessments, identify the key control and other risks in their areas and note the action proposed to address them. From time to time the internal audit unit produces reports on the key faults it identifies within the system throughout the Department or the key issues that arise in its audits.

5 Adoption of Reports

5.1. The Committee noted Vote 40 of the 2003 Appropriation Accounts and disposed of Chapters 13.1, 13.2 and 13.3 of the 2003 Annual Report of the Comptroller and Auditor General.

6 Findings and recommendations

The Committee of Public Accounts

Finds specifically that:

1. Medical assessment is an important element in the control arrangements for administering illness and disability welfare schemes. The number of claimants under short term disability schemes has increased from 42,000 in 1994 to 59,000 in 2004. Claimants under long term disability schemes have increased from 31,000 in 1994 to 73,000 in 2004 and the number of invalidity pension recipients has increased from 16,000 to 40,000 in the same ten year period.
2. The Department had recorded overpayments of €39.4 million in 2003 out of total welfare payments in excess of €10 billion. About one-third of recorded overpayments are attributed to fraud. A new unit established specifically to consider one-parent family payments increased the identified overpayments for this allowance from €1.6 million in 2002 to €8.4 million in 2003.
3. The level of criminal prosecutions increased from 205 cases in 2002 to 355 cases in 2003.

And recommends in general that:

1. An effective system of medical review and examination should balance the resources applied with the risk of inappropriate payment while minimising the burden of bureaucracy on clients.
2. The Department should improve its procedures for reconfirming appointment times for medical assessments closer to the set date.
3. The Department should keep under close review those GPs who certify persons as incapable for work who are later consistently found capable by the Department's medical assessors.
4. The Department should examine further the reasons that persons examined medically as part of their assessment for disability payments and found capable of working are then put on other schemes.
5. The Department should, in conjunction with the Office of the Revenue Commissioners, introduce further systems of integration in order to streamline both systems and so reduce the time taken to detect overpayments.