



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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Public Accounts Committee

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Opening Statement

by

Mr. Cathal Magee

Chief Executive Officer
Health Service Executive

Good morning Chairman and members of the Committee.

Thank you for the invitation to attend the Committee meeting today.

I am joined by a number of my colleagues; Ms. Laverne McGuinness, National Director Integrated Services, Mr. Declan Lyons, Assistant National Director, Finance Dublin Mid Leinster and currently Acting National Director, Finance, Mr John Swords, Head of Procurement.

Members will have received updates on each of the chapters, 42, 45 and 47 from the Comptroller and Auditor General's report 2010 and a separate Briefing Report from PCRS on medical cards as requested at the last meeting. I will therefore be brief in my opening statement.

Chapter 42 Procurement in the HSE

In his conclusion to Chapter 42 the Comptroller and Auditor General is drawing attention to the opportunity to deliver improved value through the extended use of contracts including framework agreements as well as investing in logistics and stock management systems to support the business of the HSE. The Comptroller also refers to conformance with the S40.02 reporting requirements as a means of achieving better value outcomes. The HSE has accepted these conclusions and has over the last 18 months, implemented revised management arrangements within the Procurement Directorate to better support the business and improve compliance with the procurement rule set. Over the past 18 months Procurement cost reductions of €112.7m have been delivered.

Over the past eighteen months, the Procurement Directorate has supported the organisation to achieve best value for money in terms of quality of product, service support and pricing while maintaining an appropriate level of patient and clinical choice on a Health Sector wide basis. The HSE has engaged in a significant process of review of its existing supply and services contracts. The key purpose of this process was to deliver cost savings to the HSE under existing contracts in the context of the current challenging financial environment. Among the approaches adopted by the HSE has been to, in accordance with and permitted by, the terms of the relevant contracts, to vary their terms either for the purposes of simply effecting cost reductions or to deliver better value for money to HSE in other ways (e.g. by obtaining additional services or supplies for the same overall contract sum). To date this process has delivered significant savings.

In cases where existing suppliers/service providers have been unwilling to put forward or agree cost savings, HSE is in the process of making arrangements to re-tender those services/supplies. Many of the re-tenders conducted to date have been on a national or framework basis. Economies of scale can be derived from national procurements and the use of mini competitions on frameworks can promote continued competitive tension and therefore even better value even after an initial tender exercise has been completed.

It was possible to deliver these efficiencies through the implementation of a single procurement model which involved moving to a single procurement organisation. The integrated Model is a key enabler in achieving cost reduction, increased efficiencies and the adoption of streamlined standardised procurement processes to avoid duplication of effort which is in line with leading practice for procurement.

The strategy developed to maximise procurement opportunities in 2011/12 was to harmonise pricing for existing business across the Health Sector. Tendering processes are now underway to maximise the buying power of the Health Sector through national / regional contracts. Despite the limitations in management information and IT systems, good progress has been made in the last 18 months on the issues raised in the C&AG report. The next phase of improvement will require significant upgrade of IT Procurement Systems into a single integrated model and ongoing investment in procurement capability.

Chapter 45 – Consultancy and External Support

The HSE has taken action to implement the recommendations of the Chapter. This has been achieved through the implementation of revised procedures for engaging consultancy put into place by the Procurement Directive. Expenditure on consultancy/professional services has reduced significantly in 2011. Excluding the ESRI contract for HIPE (Hospital In-Patient Enquiry Scheme), the figure is €4.6m for 2011. A listing of all consultancies and professional services in 2011 has been provided to the Committee in our update last week.

Chapter 45 of the Report of the Comptroller and Auditor General draws attention to non compliance with the HSE procedures relating to the acquisition of consulting services. The report reflects an unacceptable level of non-compliance.

While there is a strong assurance process in place in the HSE, in the absence of a single procurement system to track and control and compliance with contracts, there are weaknesses that must be addressed in the next phase. These matters are referred to in more detail in the published statement of internal financial control as part of the year end reporting process. In the HSE non compliance with the controls environment is a matter to be considered under the Disciplinary Code of the organisation.

Where necessary, management and/or internal audit undertake a report and management ensure appropriate action is taken to address non-compliance.

Chapter 47 Management of the HSE VOTE

The Primary Care Reimbursement Service manages a wide range of primary care services across 12 community health schemes, including the Medical Card Scheme, to a population of over 3.6 million people. These services are provided by more than 6,660 primary care contractors and involve 77.9 million transactions annually, with an associated expenditure of €2.517bn.

As of the 1 May 2012 there were 1,787,839 Medical Cards and 128,929 GP Visit Cards in circulation, an increase of 183,536 on the 1 January 2011 figure. When compared to 1 January 2005 there has been an increase of 771,685 cards in circulation, which is 67% more than the 2005 level.

In 2011, a major change programme was initiated, planned and developed by the HSE to centralise medical card processing in PCRS, effective from the 1st July 2011.

This was a very significant change programme which involved the redeployment and training of significant numbers of staff and considerable changes to processes which were not standardised.

The purpose of the centralisation project was to:

- Provide for a single uniform system of medical card application processing, replacing the different systems previously operated through more than 100 offices across the country.
- Streamline work processes and reduce the numbers of staff involved in medical card processing from approximately 450 to 150.
- Ultimately ensure far more accountable and better managed medical card processing system.

While considerable progress has been achieved in improving the medical card system, it is acknowledged that during the first 6 months after centralisation, a significant backlog in processing applications accumulated. The backlog which related to applications between July and December 2011 stood at 57,962 in January 2012. This backlog was successfully cleared to zero by the end of April 2012.

Review:

As part of the six month Review, Price Waterhouse Coopers also undertook a high level assessment of possible excess registrations on the Medical Card Register. In their analysis, PWC indicated a range of potential exposure if such excess registrations were to be substantiated, however they also stated that this preliminary assessment should be treated with caution and was only indicative in nature. A forensic analysis of the medical card database is already underway and this analysis is scheduled to be completed by the end of September 2012.

In relation to the outstanding legacy issued raised by the Comptroller, the HSE has completed an analysis in respect of all old cases of a time delay between the death of an individual and the DEPS notification back to 2005. The amount to be recouped is in the order of €3.095m. In parallel an analysis of the historic amount due to GPs in respect of new births was conducted and this amounts to €2.807m. Arrangements are being put in place to give effect to these repayments and recoupments. Since the processing of medical cards was centralised from July 2011 the HSE has recouped €344,791.50 automatically as part of each end of month process in respect of death events.

Income

Chapter 47 of the Report of the comptroller and Auditor General refers to the treatment of private patients in public hospitals. The conclusions refer to the opportunity to grow the income of hospitals through growth in the numbers of patients charged by ensuring they are placed in privately designated beds within hospitals. The Chapter refers to 45% of private beds in 2010 being used for public patients. This figure fell to 41% in 2011. The primary reasons for use of private beds for public patients related to managing patients with infection, providing privacy for patients and their families at the time of death and dealing with volumes of admissions through Emergency Departments.

Since the conclusion of the Chapter the Minister for Health indicated in late 2011 that he would bring forward legislation to address the bed designation issue. This would resolve the issue raised by the Comptroller.

The Chapter also referred to the fact that the HSE was submitting a business case to implement a claims management system. The business case was approved, a tender process completed and a project is underway to implement new claims management software in hospitals. This software will go live in five hospitals during 2012, Mid-Western Regional Hospital Limerick, Beaumont Hospital, Galway University Hospital, Waterford Regional Hospital and the Mercy University Hospital Cork.

This concludes my statement and together with my colleagues we will take any questions that you might have.

Thank you, Mr Chairman.