



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

PAC-R-1420 Correspondence 3C.2  
Meeting 128 – 12/06/2014

## **Chapter 21 C & G Report 2012**

### **Briefing Note for PAC 12<sup>th</sup> June 2014**

## **Budget Management in the Health Service Executive**

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## 1. Trends in Expenditure

### Trends in Net Expenditure 2009-2013 ( Based on I/E not Vote)

Annual Net Spend	2009	2010	2011	2012	2013
	€'M	€'M	€'M	€'M	€'M
HSE - Overall	13,622	12,973	12,516	12,691	12,555
Acute Hospital Services	4,450	4,140	3,895	3,883	3,935

Movement in Net Spend	2009-2012	2009-2012	2009-2013	2009-2013
	€	%	€	%
HSE - Overall	-931	-6.8%	-1,066	-7.8%
Acute Hospital Services	-567	-12.7%	-515	-11.6%

As can be seen from the table above net expenditure has fallen by €931m / 6.8% from 2009 to 2012 with a further reduction in 2013 bringing the cumulative 5 year reduction to €1,066m / 7.8%.

Net expenditure in our acute hospital services fell in cumulative terms over the 5 year period by €515m / 11.6% albeit expenditure rose by €52m / 1.3% between 2012 and 2013. When account is taken of additional hospital income generated over the period and of some of the non standard items within overall HSE spend, the underlying movement in hospital costs more closely aligns to that of other core HSE services (Primary Care, Elderly, Disabilities, Mental Health and Health and Wellbeing.)



## **2 Estimates Process for 2013**

### **2.1 Summary - Budgetary Process & Estimate Provision**

A central feature of the annual estimates process is the preparation of an 'existing level of service' costing which looks at the future costs of running a health service at static service levels but also factoring in the cost of standing still i.e. clinical inflation and the full year cost of service initiatives already underway. Allied to this process is both a service and financial review and costing of critical emerging service priorities for health based on legal, demographic and strategic perspectives.

This is done as part of the National Service Plan (NSP) process in each year and was a very clear feature for example of the 2014 estimates / service planning process which is outlined below.

The HSE has significant work to do to develop its costing systems and methodologies in order to be able to support full costing of for example, maintaining an individual with a range of chronic conditions at home or of an episode of hospital care for a specific condition. This work will require significant investment in people, processes and technology including in a new integrated financial management system to replace the many disparate financial systems that the HSE has to rely on today. As part of our Finance Reform work a business case covering this investment has recently been submitted to the Department of Health and will in due course be submitted by the Department to the Department of Public Expenditure and Reform.

However despite the very pressing need for this investment it is important to make clear that the HSE has a well developed capacity to predict its future costs at a level of detail requested of it for the annual estimates and service planning process. It also has the capacity to clearly set out assumptions and risks on which our estimates submissions and ultimately our service plan are based.

Despite the fact that the HSE can and does set out its likely future costs and the assumptions and risks underpinning what ultimately appears in the annual national service plan, it must be noted that the HSE does not control the process which leads to the setting of its overall budget. The amount allocated in relation to HSE expenditure is developed, amongst other things, against a backdrop of national budgetary objectives and the prevailing macro-economic conditions. The final estimate provision is in effect determined outside of the HSE following the conclusion of the estimates process.

### **2.2 Service Planning**

Each year the challenge to develop a NSP for the Health Service Executive (HSE) becomes more difficult as a balance is sought between the contraction in public spending and the continually increasing demand for services. Achieving an appropriate analysis of budget and resource requirements for the health sector is an essential prerequisite for the HSE in developing its annual service plan.

In previous years the primary purpose of the internal estimates process was to influence preparation of Governments Estimates. It would commence in April/May and run right through in parallel with the development of the service plan until the year end. The process (undertaken by care group) determined the emerging service priorities based on legal, demographic and strategic perspectives. These were merged with Government priorities heretofore communicated to the HSE in July each year ahead of the commencement of an intensive planning process from August onwards. During this period the interlinking dependencies of finance, human resources and service pressures were taken into account in Directorate discussions so that by Budget Day, previously in early December, the HSE NSP was well advanced with remaining decisions then focusing only on a number of emerging critical issues.

As the economic situation has deteriorated in recent years, this process has become more and more financially focused and indeed more challenging to balance delivery of a quality service, public expectations and available resources



In regard to 2014, the development of the NSP 2014 was progressed within the reality of our need to fully deliver on, and account for, the funding allocated to us by Department of Health (DoH) during the transition to a new organisational governance and accountability structure for the HSE. At all times the need to maintain safe sustainable health and personal services for the people of Ireland, was forefront in our planning.

Budget day 2014 was brought forward to October 2013 which required the internal estimates process, and service planning to commence earlier. The DoH wrote to the HSE in May outlining possible reductions /priorities to consider. Guidance and a 'rule set' was then developed which informed the estimates and planning process.

National Divisions undertook an assessment of critical need and/or investment to support reform priorities for their services. An intensive process took place over a three month period June to August 2013, the outcome of which was discussed, and resource requirements endorsed, at Leadership and Directorate level.

Following formal submission to DoH at end September, discussions then ensued at relevant levels including senior official, accounting officer and ministerial both pre and post budget until formal notification of the HSE Vote was received.

### 3 Budget Monitoring – 2012

If we examine the summary financial performance of the HSE through an analysis of the vote expenditure which is the currently the primary measure from the perspective of the Director General as Accounting Officer:

- The surplus to be surrendered, post the supplementary estimate amounted to **€22.8m** in 2012.
- The supplementary amounted to **€360m or 3%** of the original net Vote with **€337m / 2.8%** being eventually required and the balance of €22.8m returned to the exchequer.
- €227m of the supplementary estimate related to the PCRS (Medical Cards / GP fees, Drugs and Other demand led Schemes, DTSS etc).
- **€181m of the supplementary estimate which also equates to 1.5% of the original net vote was related to a mix of deficits on core services, primarily hospitals and miscellaneous surpluses.**



## 4 Budget Monitoring 2008 to 2013

On the same basis as above if we look at the summary financial performance of the HSE for the period 2008 – 2013:

HSE Supplementary Estimates 2008 - 2013						
Years(s)	PCRS	Other HSE	Sub-total	Exchequer / Outside HSE Control	Overall Total	Original Net Vote
	€m	€m	€m	€m	€m	€m
2008-2011	152	-12	140	1,279	1,419	46,804
2012	227	181	408	-48	360	12,161
2013	96	-25	71	148	219	12,312
	475	144	619	1,379	1,998	71,277
% of Original Net Vote	0.67%	0.20%	0.87%	1.93%	2.80%	

*Note: This table summarises the main items in the supplementary estimates as passed by Dáil Éireann. Other individual savings and overspends would have arisen each year which were dealt with by the Virement process.*

➤ Over the 6 years from 2008 to 2013 there has been:

- **€144m** in net supplementary estimates to the HSE in respect of areas within its direct control which equates to **0.20%** of the €71.277bn total original net vote over the period.
- **€475m** in supplementary estimates to the HSE in respect of PCRS (Medical Cards / GP fees, Drugs and Other demand led Schemes, DTSS etc) which equates to **0.67%** of the €71.277bn total original net vote over the period.
- It should be noted that an initial review of the HSE Service Plans for 2008 to 2013 indicates that during these 6 years a total of **€1,048m** was listed as savings targets for the areas covered within PCRS. While further analysis is required it is possible to deduce from this that over the period €1,048m was taken from the HSE / PCRS budget with at least €573m reflected in savings and €475m returned via the supplementary.
- **€1,379m** in supplementary estimates to the HSE in respect of Exchequer related and other items outside of the control of the HSE which equates to **1.93%** of the €71.277bn total original net vote over the period

Exchequer - Health Contributions (2008-2011)	524	Income Legislation (2013)	62
Exchequer - Long Stay Repayment Scheme (2008-2011)	86	Recovery of Private Health Insurers Advance (2013)	103
Exchequer - Other Initiatives (2008-2011)	391	Pension and Service Development Savings (2013)	-114
Exchequer - UK Receipts (2008-2011)	278	Additional Receipts from UK and SIF (2013)	-10
Payments to the State Claims Agency (2012)	-20	PSA II (Pre agreement finalisation) (2013)	70
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		<b>Total</b>	<b>1,379</b>



## 5 Medical Care Service and Community Services (Primary Care Reimbursement Service)

### 5.1 The key reasons for the overrun €238m in 2012 were:-

1. 50,000 medical cards more than planned – extent became visible following centralisation.
2. There was a €124m cost-reduction target in the 2012 Service Plan. The finalisation of the IPHA<sup>1</sup> took place later than expected with the result that savings of €15m were achieved against the €124m – leaving a shortfall of €109m.
3. There were overruns on local schemes such as hardship medicines which are largely demand led.
4. There were overruns on Hi-Tech medicines (where new drugs are charged – for example cystic fibrosis).

### 5.2 Drug Cost Agreement

In October 2012, a major new deal on the cost of originator drugs was concluded with the Irish Pharmaceutical Healthcare Association (IPHA), which will deliver a number of important benefits, including significant reductions for patients in the cost of drugs, a lowering of the drugs bill to the State, timely access for patients to new cutting-edge drugs for certain conditions, and reducing the cost base of the health system into the future. The gross savings to the GMS and other demand led schemes arising from this deal are estimated to be in excess of €400 million over 3 years. €210 million from the gross savings will be available to fund new drugs.

A new agreement was also reached with the Association of Pharmaceutical Manufacturers in Ireland (APMI) in October 2012. Since 1 November 2012, the maximum price the HSE pays for generic products is 50% of the initial price of an originator medicine. Recent negotiations with the APMI have resulted in agreement on additional price reductions and, from 1 May 2014, the maximum price the HSE will pay will be 40% of the initial price of an originator medicine. This will result in the price differential between off-patent drugs and most generic equivalents increasing from 5% currently to approximately 20%.

The combined gross savings from the IPHA and the APMI agreements were in excess of €120 million in 2013 with an additional €28 million profiled savings in 2014. The current year results to end of April 2014 include savings achieved of €7.7m.

### 5.3 Cost of Medical and GP Visit Cards

In 2012, the Medical card and GP Visit card overrun was attributed to two factors,

1. An increase in the number of individuals who became eligible for a card versus the number profiled. This was due to clearing of a backlog in processing of cards following centralisation in 2011 and a greater than profiled number of individuals becoming eligible due to a change in personal circumstances, and
2. The use of estimated average costs for drugs and payments to a cardholder based on age profile. We have determined that the use of price and volume analysis on cards for cardholders who are at “end of life” stage of treatment can result in variances to profile in terms of fees, prescribed medication and high tech medication.

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<sup>1</sup> The IPHA agreement involves the Department of Health, the Irish Pharmaceutical Healthcare Association and the HSE. The 2012 agreement was completed in October 2012 following discussions co-ordinated by the DOH with planned savings over a 3 year period of €400m.



#### **5.4 Number and cost of cards**

At the end of December 2012, the total number of cards in issue was 1.985m. This was reduced by 10,000 cards to 1.975m at the end of 2013. By the end of April 2014 a further reduction of almost 50,000 cards resulted in a total number of cards in issue of 1.925m.

2013 total medical card costs were €1,856.7m and costs year to date to end of April 2014 are €578.6m.

In 2013, changes were made in legislation regarding the income threshold of the Over 70's and came into effect with a commencement order on 19 April 2013. The legislation allowed clients to retain their cards until the end of May 2013. The guidelines were further reduced in Budget 2014 with effect from 1 January 2014. This change allowed clients to retain their cards until the end of February 2014. These changes have resulted in underlying savings in 2013 of €12m and potential profiled savings in 2014 of €25m. The current year results to end of April 2014 include savings achieved of €3.2m.

Changes were also made to guidelines in 2013 which disregarded certain types of income which resulted in a €20m saving in 2013. The full year effect of the changes in legislation and guidelines is budgeted to be €23m in 2014. The current year results to end of April 2014 include savings achieved of €10.9m.

Data sharing with Revenue since late 2013 has also allowed the HSE to target for review high-income individuals who may not be eligible for a card. Costs savings are expected from these targeted reviews. Data sharing with DSP will also generate savings in 2014.

#### **5.5 Explanation for cost over runs – including the residual €90m referenced in Chapter 21**

There is full clarity on the components of the cost overrun in PCRS for 2012 and this includes the residual €90m referenced in the chapter. Line by line detail in this regard has been provided to the C&AG.

Accordingly it is important to stress that there is no unexplained expenditure. All public funds were appropriately accounted for and the HSE has provided a full analysis of expenditure to the C&AG in respect of 2012 and all previous years.

The breakdown of the €90m referred to in the conclusion of chapter 21 is comprised of -

- a. An overrun in the local schemes and the community drug schemes such as High Tech medicines arrangement – as the requirement for High Tech drugs is demand led, and with new costly drugs being made available it can be difficult to forecast increased costs year on year.
- b. Costs associated with centralisation of medical cards.  
Centralisation has reduced the overall costs associated with administration of medical card schemes. However it required additional resource in PCRS and allowed local services to operate with less administrative staff and / or redirect to other priority areas.

## 6 Hospital Budget Overruns & Budget Setting Process 2013

The net expenditure **budget** for Acute Hospitals has fallen from €4,495m in 2008 to € 3,729m in 2013 which is a reduction of € 766m or 17%. When account is taken of increased income targets the budget to cover gross costs (Pay and Non Pay) has fallen by in the region of 10% over the period. Over the same period:

- i. Combined inpatient, day case and births activity has increased by circa 15%
- ii. Bed days used has reduced by circa 10%
- iii. Emergency Department presentations are up by circa 6%

As indicated at i. above hospital **costs** have also fallen over the this period however this has not kept pace with the budget reductions leading to over runs each year and an underlying deficit in hospitals.

In creating hospital budgets for 2013 the HSE undertook to begin to address the carried forward deficit and provide budgets for hospitals through a “system wide rebalancing” to support the 2012 activity level and the cost increases due to demographic, technology and clinical advancements.

This initiative was one part of a programme of reform in the hospital sector, a programme which includes the establishment of hospital groups.

While this rebalancing brought €241m into hospital budgets it is important to note that there were not sufficient funds available to the HSE to provide a 2013 budget that at least matched the 2012 cost level of the hospitals.

This financial reality also underscores the 2014 budget which despite rebalancing a further €50m into hospital budgets provides a starting 2014 budget of €3,736m compared to a 2013 net cost of €3,935.

This €199m / 5% challenge is partly offset by the Haddington Road Agreement (HRA) which makes available to hospitals an estimated minimum 2% / €80m in savings over and above what HRA made available to hospitals in 2013 leaving a requirement to reduce costs in real terms by 3% which includes at least €56m / 1.4% of undelivered 2013 cost containment plans that need to be addressed in 2014.



## 7. The Acute Hospital System - Money Follows the Patient (MFTP) - Approach to Implementation and Progress to Date

Full roll-out of MFTP is a multi-year project and a phased approach to implementation is being taken in order to ensure operational stability in hospitals. Phase 1 of MFTP commenced on schedule in January 2014, across all 38 Casemix Hospitals. During this phase, the MFTP approach will apply to an 'earmarked' element of the 2014 fixed budget. The earmarked element is derived using specified activity together with set prices. All other elements of hospital activity will continue to be funded within the balance of the fixed budget. **It is important to emphasise the point that MFTP is at the beginning of a process that will take a number of years and will be critically dependant on the investment in people, process and technology referred to at 2.1 above.**

The overarching goal for Phase 1 is to mobilise the acute system and launch the new funding system. A number of objectives have been set as follows:-

- Explicitly link activity targets with finance,
- Implement financial penalties to hospitals if they are not compliant with agreed targets,
- Elevate the priority that HIPE coding is granted in the hospitals as the hospitals will be performance managed on their activity each month,
- Involve clinicians to a greater degree with their own HIPE data in order to improve data integrity and
- Establish activity targets that include patient-access targets as well as specified volumes.

### Progress on Achievement of Objectives

Hospitals have been allocated their full budget in 2014 and are receiving this funding as part of the normal budgetary process. They are not as yet receiving itemised payments per episode of care, however, a major element of their budget is "earmarked" as MFTP. The MFTP component will be analysed on a monthly basis.

Hospitals have been informed that where planned activity levels have not been delivered, the value of the resulting shortfall will be determined. Under Phase 1 of the project, hospitals will not receive additional funding for delivering more activity than has been agreed. MFTP will not fund such activity and the hospital will have a deficit on this basis unless the additional activity is carried out within existing funding.

The entire envelope of funding is being divided between the hospitals and, as such, there is no additional fund to provide activity beyond agreed levels. The need for control has been clearly expressed to the hospitals.



## **8. Collecting Patient Charge Income**

This note focuses on acute hospital patient income of which approximately 90% relates to private charges paid by health insurance companies on behalf of their members.

### ***Update on Collection – Comparison of year end 2012 with yearend 2013***

Claims awaiting action by consultants / hospitals have fallen by €9.2m / 10% or by 5 “debtor days” / 7.5% which represents a continued improvement over a number of years by hospitals in the part of the process they have control over.

This improvement has been assisted by a number of factors including sustained management focus, greater co-operation from consultants and the further rollout of the electronic claims management system (Claimsure). This system is now running in 27 public hospitals, handling nearly 81% of the value of all claims, and is due to go live in a further 20 hospitals this year. This system is significantly improving claim tracking and management processes within the hospitals where it is installed.

However the overall position worsened by €24.3m due to the fact that insurers increased the amounts awaiting payment to hospitals by €33.5m / 34% with debtor days increasing by 26 days / 37%.

### ***Outlook / Key issues***

Even with the assistance of the electronic claims management system the claims process is an onerous one which increasingly prevents hospitals being able to bill quickly or collect income in reasonable time. In summary the process, which is not designed or controlled by the HSE, is not designed for the efficient billing and collection of the statutory charge.

The hospital is unable to issue its bill for the statutory charge until it has gathered up and has validated a significant amount of additional paperwork which relates primarily to the payment to be made by the insurer to the relevant consultant(s) and other professionals.

Significant funds are tied up by the current process (€241m at Apr'14). If normal credit terms of 30 days applied and the hospital could submit its bill upon discharge, the amount of the debt would be circa €42m. The HSE has repeatedly argued that its bill is in respect of a statutory charge for a patients stay in the hospital and should be treated separately. Hospitals should be allowed issue their bill on the day of discharge and should be paid within 30 days, perhaps with a standard retention being deducted by the insurance company. This retention would ensure that the necessary additional paperwork could be submitted within an agreed time.

It is important to stress that the HSE shares a common goal with insurers to be satisfied that patients receive safe appropriate treatment at the lowest cost. However it is not appropriate that the insurance companies would effectively use the HSE to provide them with a free overdraft facility by refusing to accept bills until the additional information is provided and then withholding any payment for the statutory charge until they have satisfied their own internal requirements.

The HSE will continue to engage with the Department of Health and the Private Insurers to seek to improve the collection process however in its current form it does not facilitate efficient debt collection by hospitals and cannot be compared to standard debt collection norms.

The introduction of the new charging regime in 2014 (Health Amendment Act 2013) went ahead from the start of the year and its impact on income generation in the current year is currently being assessed.



## **9. Pensions Lump Sums Provision**

The HSE budgeted for circa about €207 million in relation to pension lump sums for retiring employees in 2012. In 2012, expenditure in relation to lump sum payments was €175.5 million — €31.5 million less than expected. The number of people who retired was almost 2,000 less than anticipated. In 2013 the HSE reported an overall pension's surplus of €133.47m, which was again attributable to the lower than anticipated number of leavers, as well as significantly reduced average lump sum and pension payments.

A key driver in the lower than expected number of retirees over the last two financial years has been the abnormally high number of leavers in 2011 in addition to the provision and then extension of the grace period. In light of this fact and with the extension now stretched to June 2015 it is difficult to predict with certainty the numbers that will leave the HSE in 2014.





Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

## **Vote 39 Health Service Executive 2012**

### **Briefing Note for PAC 12th June 2014**

## **Appropriation Account 2012 & Summary Financial Performance 2008 to 2013**



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## 1. Financial Performance Summary 2008 – 2013

HSE Supplementary Estimates 2008 - 2013						
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		<b>Total</b>	<b>1,379</b>



## 2. Summary Financial Performance in year 2012

- The surplus to be surrendered, post the supplementary estimate amounted to **€22.8m** in 2012.
- The supplementary amounted to **€360m or 3%** of the original net Vote with **€337m / 2.8%** being eventually required and the balance of €22.8m returned to the exchequer.
- €227m of the supplementary estimate related to the PCRS (Medical Cards / GP fees, Drugs and Other demand led Schemes, DTSS etc).
- **€181m of the supplementary estimate which also equates to 1.5% of the original net vote was related to a mix of deficits on core services, primarily hospitals and miscellaneous surpluses.**

## 3. Summary Financial Performance in year 2013

- The surplus to be surrendered, post the supplementary estimate amounted to **€31m** in 2013.
- The supplementary amounted to **€219m or 1.8%** of the original net Vote with **€188m / 1.5%** being eventually required and the balance of €31m returned to the exchequer.
- €148m of the supplementary related to issues outside of the HSE's control (€103m reversal of accelerated income from 2012, €70m PSA II budget reduction in advance of agreement, €62m income not collected due to deferral of legislation and €37m excess in state claims agency costs offset by savings of €124m in pensions, service developments and additional receipts from the UK and SIF).
- Outside of these areas the HSE delivered a €25m surplus made up of deficits on core services primarily hospitals and surpluses on capital and other services.
- In addition there was a deficit of €96m deficit on PCRS (Medical Cards / GP fees, Drugs and Other demand led Schemes, DTSS etc).
- **This indicates a combined €71m deficit relation to the areas within HSE control and PCRS which equates to 0.6% of the net original vote.**

## 4. 2012

### 4.1 Net Allocation and outturn 2012

<b>Net Allocation 2012</b>	<b>€'000</b>
Net Revenue Allocation	11,786,933
Net Capital Allocation	374,000
<b>Net Revenue &amp; Capital Allocation</b>	<b>12,160,933</b>
<sup>1</sup> Supplementary Estimate 2012	360,000
<sup>2</sup> Final Net Allocation	12,520,933
<b>Outturn per Appropriation Account</b>	<b>12,498,099</b>
<b>Surplus liable for surrender</b>	<b>22,834</b>

The surplus liable for surrender to the Exchequer was €22,833,999.

### 4.2 Supplementary Estimate – passed by the Dáil on the 11th December 2012

The Supplementary Estimate 2012 was provided for the following expenditure pressures:-

- Activity levels in hospitals in excess of targets;
- Decline in Income from private health insurance; and
- Increase in expenditure on Medical Cards and Drugs.

The underlying deficit in 2012 was circa €100m higher but the once off advance from the insurance companies reduced the supplementary requirement to €360m. For details see Appendix A.

A total of €104m was received in December 2012 from negotiated legal agreements whereby the private insurance companies advanced funds in respect of patients treated but not yet invoiced by nominated HSE and voluntary hospitals.

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<sup>1</sup> See Appendix A

<sup>2</sup> See Appendix A



### **4.3 Audit of the Appropriation Account 2012 & Audit Certificate by C&AG**

The Comptroller and Auditor General signed the HSE Appropriation Account for 2012 on the 27<sup>th</sup> September 2013 with a clean audit certificate.

In the opinion of the Comptroller and Auditor General:

*"the appropriation account properly presents the receipts and expenditure of Vote 39 Health Service Executive for the year ended 31 December 2012.*

#### **Reporting on matters arising from audit**

Chapter 21 of my report on the accounts of the public services for 2012 relates to budget management in the health sector. Chapter 22 relates to medical card eligibility.

#### **Compliance with Procurement Guidelines**

*I also draw attention to the Statement on Internal Financial Control and the section therein which sets out the material instances of non-compliances with public procurement guidelines and provides details of the proposed actions to address these weaknesses."*

## 5. 2013

### 5.1 Draft 2013 Appropriation Account

The Revised Estimates Volume 2013 provided for a net vote estimate of €12,312m for the HSE. A net supplementary estimate of €219m was passed by the Dáil on the 12<sup>th</sup> December 2013 to fund expenditure pressures and deficits as detailed below.

The surplus to be surrendered for 2013 of €31.074m accounts for 0.2% of the total net Estimate for 2013. The Appropriation Account for 2013 is currently subject to audit and the individual subhead outturn will not be available until the audit is completed.

Category	2013 REV Estimate	Supplementary Estimate	Final 2013 Estimate	2013 Outturn	(Surplus) / Deficit
	€'000	€'000	€'000	€'000	€'000
Gross Revenue	13,392,623	170,000	13,562,623	13,537,828	-24,795
Gross Capital	381,000	-50,000	331,000	335,002	4,002
<b>Total Gross Vote</b>	<b>13,773,623</b>	<b>120,000</b>	<b>13,893,623</b>	<b>13,872,830</b>	<b>-20,793</b>
<b>Appropriations-in-Aid</b>					
Revenue Receipts	-1,453,152	99,000	-1,354,152	-1,366,167	-12,015
Capital Receipts	-8,000	0	-8,000	-6,266	1,734
<b>Total Appropriations-in- Aid</b>	<b>-1,461,152</b>	<b>99,000</b>	<b>-1,362,152</b>	<b>-1,372,433</b>	<b>-10,281</b>
<b>Net Vote</b>	<b>12,312,471</b>	<b>219,000</b>	<b>12,531,471</b>	<b>12,500,397</b>	<b>-31,074</b>

<b>Net Revenue</b>	<b>11,939,471</b>	<b>269,000</b>	<b>12,208,471</b>	<b>12,171,661</b>	<b>-36,810</b>
<b>Net Capital</b>	<b>373,000</b>	<b>-50,000</b>	<b>323,000</b>	<b>328,736</b>	<b>5,736</b>
<b>Net Vote</b>	<b>12,312,471</b>	<b>219,000</b>	<b>12,531,471</b>	<b>12,500,397</b>	<b>-31,074</b>

### 5.2 Supplementary Estimate 2013

The net supplementary estimate required for the HSE Vote was €219m. This had three components:

Category	Supplementary Estimate €m
Net revenue - HSE	279
Net capital – HSE	(50)
Other HSE Vote receipts	(10)
<b>Net supplementary required</b>	<b>219</b>



The primary factors giving rise to the supplementary estimate are set out below.

Category	€m	Notes
Income Legislation	62	Legislation to charge private patients in public beds will take effect from 1 <sup>st</sup> January 2014.
Recovery of Private Health Insurers Advance	103	Private insurance companies have fully recouped the accelerated receipts paid in December 2012 resulting in a once-off cash shortfall in 2013.
PCRS	66	Delay in implementing FEMPI regulations and a shortfall in non-FEMPI savings targets.
Local Schemes	30	The nature of expenditure and low level of potentially discretionary aids / appliances mitigating against potential for savings.
Haddington Road	70	REV target set before deal concluded.
Children and Family Services	15	Deficit in Childcare Legal Services.
Procurement Savings Shortfall	10	Ability to isolate and analyse the realised cost savings exacerbated by financial systems.
State Claims	37	Estimate of claims due for payment from State Claims Agency.
Pension Lump Sums / Other Savings / Other Overruns	-114	HSE to request approval to utilise any surplus in pensions and time related savings in the 2013 mental health and primary care reinvestments within the relevant care groups.
<b>Total</b>	<b>279</b>	

## 6. Revised Estimates Volume 2014

The Revised Estimates Volume 2014<sup>3</sup> provided for a net vote estimate of €11,552m for the HSE for 2014.

Category	REV 2014	REV 2013	Reduction	Add Transfer to CFA	Underlying HSE Reduction
	€'000	€'000	€'000	€'000	€'000
Gross Revenue	12,583,650	13,392,623	-808,973	36,743	-272,230
Net Revenue	11,186,337	11,939,471	-753,134	516,504	-236,630
Gross Capital	374,159	381,000	-6,841	6,841	0
Net Capital	366,159	373,000	-6,841	6,841	0
<b>Net Vote</b>	<b>11,552,496</b>	<b>12,312,471</b>	<b>-759,975</b>	<b>523,345</b>	<b>-236,630</b>

The underlying HSE reduction of €237m in cash terms from 2013 does not fully reflect the challenges faced by the HSE in 2014 as figures for incoming deficits and new financial pressures etc are not readily apparent from the figures.

<sup>3</sup> See Appendix 3 for Published REV 2014

# Appendix A - Revised Estimates Volume 2012, Supplementary Estimate and Outturn

	REV 2012	Supplementary Estimate	Final Allocation	Outturn per Appropriation Account	Variance
<b>Gross Revenue</b>	<b>13,332,455</b>	<b>348,000</b>	<b>13,680,455</b>	<b>13,646,294</b>	<b>-10,655</b>
HSE AinA	1,144,917	-31,000	1,113,917	1,097,261	-16,656
Other AinA	400,605	-9,000	391,605	387,605	-4,000
<b>Total AinA</b>	<b>1,545,522</b>	<b>-40,000</b>	<b>1,505,522</b>	<b>1,484,866</b>	<b>-20,656</b>
<b>Net Revenue Vote</b>	<b>11,786,933</b>	<b>388,000</b>	<b>12,174,933</b>	<b>12,161,428</b>	<b>-13,505</b>
<b>Gross Capital</b>	<b>382,000</b>	<b>-28,000</b>	<b>354,000</b>	<b>341,150</b>	<b>-12,850</b>
AinA	8,000		8,000	4,479	-3,521
<b>Net Capital</b>	<b>374,000</b>	<b>-28,000</b>	<b>346,000</b>	<b>336,671</b>	<b>-9,329</b>
<b>Net Vote 2012</b>	<b>12,160,933</b>	<b>360,000</b>	<b>12,520,933</b>	<b>12,498,099</b>	<b>-22,834</b>

<b>Supplementary Estimate 2012</b>	<b>€m</b>
Deficits in services (after application of time-related savings)	162
PCRS	234
Unachieved income	40
<b>Total</b>	<b>436</b>
<b>Savings on subheads</b>	
Pension Lump Sum Payments	-8
Service Developments and innovative service delivery projects	-20
Payments to the State Claims Agency	-20
Capital	-28
<b>Total Savings</b>	<b>-76</b>
<b>Gross Supplementary Requirement</b>	<b>360</b>



## Appendix B – 2014 - Additional Tables – Extract from National Service Plan 2014

The Service Plan for 2014 further analysed the allocation in this regard as follows:

<b>REV 2013 to REV 2014 – NET ALLOCATION</b>	<b>€m</b>
<b>REV 2013</b>	<b>12,312</b>
Demographic pressures (See Appendix 1)	62
Maintenance and expansion of critical services (See Appendix 2)	59
Incoming service pressures	126
Programme for Government - Mental Health	20
Programme for Government GP services for children aged 5 years and under	37
Transfer from DoH Vote re Drugs Schemes	22
Community (Demand-Led) Schemes* (Note 1)	-294
Pay and Pay Related Savings* (Note 2)	-268
Other Savings Measures* (Note 3)	-36
A-in-A Adjustments* (Note 4)	36
<b>NET Allocation before CFA Transfer</b>	<b>12,076</b>
<b>Transfer to CFA</b>	<b>-523</b>
<b>HSE REV 2014</b>	<b>11,553</b>

\* Total savings of €619m are detailed in Note 5

### Note 1 Community (Demand-Led) Schemes

Table 6: The Community (Demand-Led) Schemes

	Cm
<b>GROSS REV 2013</b>	<b>2,520.0</b>
<b>Estimates Measures</b>	
Medical Cards	35.0
GP services for children aged five years and under	37.0
Dental Treatment Services Scheme	12.0
Full Year Cost of 2013	60.0
<b>Sub-total</b>	<b>144.0</b>
IPHA / APMI Agreement	-28.0
Full year effect of FEMPI fee reductions	-37.0
Full year impact of increase in prescription charges	-4.0
Full year effect of income thresholds and probity	-23.0
Generic substitution and drug reference pricing	-50.0
Reduce Income Thresholds for the over 70s Medical Card (€900 p.w. couple and €500 p.w. single)	-25.0
Additional delisting of drugs from the GMS reimbursable drugs	-10.0
Instead of retention of full medical card on return to work, give GP Visit Card	-11.0
Increase prescription charge to €2.50 per item with €25 cap	-43.0
Medical card probity	-113.0
Revised Estimate Provisions	47.0
<b>Subtotal*</b>	<b>-297.0</b>
Adjustment to base funding	63.0
Other Adjustments	3.0
<b>Total estimates adjustment</b>	<b>-87.0</b>
<b>GRAND TOTAL</b>	<b>2,433.0</b>

\*An additional €3m target has been given under Income and Probity measures



## Appendix B (Continued) – 2014 - Additional Tables – Extract from National Service Plan 2014

### Note 2 Pay and Pay Related Savings

#### Pay-related reductions

The 2014 Estimate includes reductions of €268m for pay and flexibility measures. The budget reduction applied to the Health Service in 2013 was €150m, making a total of €418m under the *Haddington Road Agreement* and unspecified pay measures.

Table 9: Pay and Pay-Related Expenditure

Pay cost adjustments – Haddington Road Agreement Pay and Flexibility Arrangements	€m
Haddington Road Agreement	-140.0
Unspecified pay savings	-108.0
Employment Control Framework	-20.0
<b>Total</b>	<b>-268.0</b>

### Note 3 Other Savings Measures

Other Savings Measures	€m
Nurse Bank	-12.0
Legislation to charge all private patients in public hospitals (Voluntary Hospitals)	-14.4
NHSS - A Fair Deal – Full year effect of adjusting the asset-based contribution – Legislation in 2013	-10.0
<b>Total</b>	<b>-36.4</b>

Note: The NHSS increased asset contribution was included in the Abridged Estimates Volume at €10m, and will be corrected in the Revised Estimates Volume to €3m

### Note 4 A-in-A Adjustments

Changes to Statutory Income Target (Appropriations-in-Aid)	€m
2013 A-in-A Target	1,453.2
Reversal of 2013 statutory hospital income target	-31.2
Loss of income from EU Receipts (UK agreement)	-30.0
Collection of EU charges	5.0
Licensing of Tobacco retailers (Dependent on new legislation)	5.0
2014 statutory Hospitals income target	15.6
<b>Total Adjustments</b>	<b>-35.6</b>
<b>Total A-in-A Estimate 2014</b>	<b>1,417.6</b>

## Appendix B (Continued) – 2014 - Additional Tables – Extract from National Service Plan 2014

### Note 5 The Reductions required in the Health Service in 2014

Table 4: The reductions required in the Health Service in 2014

Unavoidable Pressures	€m
Primary Care Reimbursement Service (PCRS)	-294.0
Pay and Flexibility Measures	-268.0
Other Savings Measures	-36.4
<b>Total Reductions</b>	<b>-598.4</b>
2014 Statutory Income Target – Refer to note below	-20.6
<b>Total Reductions</b>	<b>-619.0</b>

Note: The 2014 statutory income target includes €15.60m for statutory hospitals and a further €5m for the licensing of tobacco retailers. The latter target is dependent on the introduction of new legislation. The statutory target excludes the voluntary income target to charge all private patients in public hospitals which is included in other savings measures - Table 2.



# Appendix C – Vote 39 – HSE – Revised Estimates Volume – 2014

[39]

Health Service Executive

[39]

39

## HEALTH SERVICE EXECUTIVE

- I. Estimate of the amount required in the year ending 31 December 2014 for the salaries and expenses of the Health Service Executive and certain other services administered by the Executive, including miscellaneous grants.

Eleven thousand, five hundred and fifty-two million, four hundred and ninety six thousand euro

(€11,552,496,000)

- II. Subheads under which this Vote will be accounted for by the Health Service Executive.

	2013 Estimate*			2014 Estimate			Change 2014 over 2013
	Current	Capital	Total	Current	Capital	Total	
	€000	€000	€000	€000	€000	€000	%
<b>HSE ADMINISTRATION</b>							
A 1 - SALARIES, WAGES AND ALLOWANCES AND OTHER ADMINISTRATION EXPENSES OF CORPORATE HSE	61,831	-	61,831	61,557	-	61,557	-
A 2 - VALUE FOR MONEY AND POLICY REVIEWS	389	-	389	386	-	386	-1%
A 3 - PENSION LUMP SUM PAYMENTS	72,000	-	72,000	72,000	-	72,000	-
Subtotal	134,220	-	134,220	133,943	-	133,943	-
<b>HSE REGIONS AND OTHER HEALTH AGENCIES</b>							
B 1 - HSE - DUBLIN MID LEINSTER REGION	1,370,558	-	1,370,558	1,355,461	-	1,355,461	-
B 2 - HSE - DUBLIN NORTH EAST REGION	1,230,277	-	1,230,277	1,234,692	-	1,234,692	-
B 3 - HSE - SOUTH REGION	1,941,893	-	1,941,893	1,928,812	-	1,928,812	-
B 4 - HSE - WEST REGION	2,157,958	-	2,157,958	2,141,394	-	2,141,394	-
B 5 - GRANTS IN RESPECT OF CERTAIN OTHER HEALTH BODIES INCLUDING VOLUNTARY AND JOINT BOARD HOSPITALS	2,237,306	-	2,237,306	2,206,786	-	2,206,786	-1%
Subtotal	8,937,992	-	8,937,992	8,867,145	-	8,867,145	-
<b>OTHER SERVICES</b>							
B 6 - HEALTH AGENCIES AND OTHER SIMILAR ORGANISATIONS (PART FUNDED BY NATIONAL LOTTERY)	7,513	-	7,513	7,513	-	7,513	-
B 7 - HOSPITAL IN-PATIENT, OUT-PATIENT AND COUNSELLING SERVICES FOR PERSONS WHO HAVE CONTRACTED HEPATITIS C FROM THE USE OF IMMUNOGLOBULIN ANTI-D AND THE PROVISION OF SERVICES UNDER THE HEALTH (AMENDMENT) ACT 1996	14,458	-	14,458	14,244	-	14,244	-1%
B 8 - PAYMENT TO A SPECIAL ACCOUNT ESTABLISHED UNDER SECTION 13 OF THE HEALTH (REPAYMENT SCHEME) ACT 2006	8,000	-	8,000	8,000	-	8,000	-
B 9 - PAYMENT TO A SPECIAL ACCOUNT ESTABLISHED UNDER SECTION 4 OF THE HEPATITIS C COMPENSATION TRIBUNAL (AMENDMENT) ACT 2006 - INSURANCE SCHEME	1,500	-	1,500	1,500	-	1,500	-
B 10 - SERVICE DEVELOPMENTS AND INNOVATIVE SERVICE DELIVERY PROJECTS	66,600	-	66,600	41,570	-	41,570	-38%
B 11 - PAYMENTS TO THE STATE CLAIMS AGENCY	133,000	-	133,000	96,000	-	96,000	-28%
Subtotal	231,071	-	231,071	168,827	-	168,827	-27%
<b>CARE PROGRAMME</b>							
C 1 - PRIMARY CARE REIMBURSEMENT SERVICES AND COMMUNITY DEMAND LED SCHEMES	2,624,756	-	2,624,756	2,374,972	-	2,374,972	-10%
C 2 - LONG TERM RESIDENTIAL CARE	974,273	-	974,273	938,763	-	938,763	-4%
C 3 - CHILDREN AND FAMILY SERVICES**	540,321	1,000	541,321	-	-	-	-
Subtotal	4,139,350	1,000	4,140,350	3,313,735	-	3,313,735	-20%
<b>CAPITAL SERVICES</b>							
D 1 - BUILDING EQUIPPING AND FURNISHING OF HEALTH FACILITIES AND OF HIGHER EDUCATION FACILITIES IN RESPECT OF THE PRE-REGISTRATION NURSING DEGREE PROGRAMME, INCLUDING PAYMENTS IN RESPECT OF PROPERTY RENTAL, LEASE COSTS, ETC	-	279,461	279,461	-	323,620	323,620	16%
D 2 - BUILDING EQUIPPING AND FURNISHING OF HEALTH FACILITIES (PART FUNDED BY NATIONAL LOTTERY)	-	2,539	2,539	-	2,539	2,539	-

\* 2013 Estimate includes a Supplementary Estimate of €219,000,000

\*\* Includes transfer of funding from the HSE for Children and Family Services in the context of the establishment of the Child and Family Agency.

		2013 Estimate*			2014 Estimate			Change 2014 over 2013
		Current	Capital	Total	Current	Capital	Total	
		€000	€000	€000	€000	€000	€000	%
<b>CAPITAL SERVICES - continued</b>								
D.3 -	INFORMATION SYSTEMS AND RELATED SERVICES FOR HEALTH AGENCIES	100,000	40,000	140,000	100,000	40,000	140,000	-
D.4 -	BUILDING AND EQUIPPING MENTAL HEALTH AND OTHER HEALTH FACILITIES (FUNDED FROM THE DISPOSAL OF SURPLUS ASSETS)	-	8,000	8,000	-	8,000	8,000	-
	Subtotal :-	100,000	320,000	430,000	100,000	374,159	474,159	10%
	Gross Total :-	13,562,623	331,000	13,893,623	12,583,650	374,159	12,957,809	-7%
	Deduct :-							
E -	APPROPRIATIONS-IN-AID	1,354,152	8,000	1,362,152	1,397,313	8,000	1,405,313	3%
	Net Total :-	12,208,471	323,000	12,531,471	11,186,337	366,159	11,552,496	-8%
Net Decrease (€000)								-978,975
Exchequer pay included in above net total		5,871,247			5,414,883			-8%
Associated public service employees		98,935			94,209			-3%
Exchequer pensions included in above net total		581,714			464,614			-20%
Associated public service pensioners		37,260			39,072			5%
* 2013 Estimate includes a Supplementary Estimate of €219,000,000								





*22.1 Procedures for processing medical card applications and renewals have been enhanced during 2013. The HSE plans to conduct additional internal reviews to ensure the prescribed controls are being applied.*

**HSE Update:** This is correct. Each month a selection, which have being processed are subject to QA review, checking and any training matters which arise. This happens with medical card new applications / medical card renewals and phone calls processed. Standard operating procedures have been enhanced and additional training has been completed.

\*\*\*\*\*

*22.2 Additional processing review capacity is being provided in 2013 to perform the required number of reviews.*

**HSE Update:** This additional capacity was added through a tendering procedure and a contract, which is in place. A managed service provider uses the same HSE computer systems and the same assessment procedures. Call centre capacity was also increased to maintain service levels as the level of review activity increased.

\*\*\*\*\*

*22.3 The HSE plans to conduct a full review of a sample of cases who have confirmed eligibility by way of cardholder self-assessment. This will serve as a control on the self-assessment process,*

**HSE Update:** This procedure has been introduced whereby a small percentage (typically representing approx. 100 cases), which had been subject to self-assessment are re-initiated again as full renewals. This procedure will re-commence once the Over 70s review programme, which is currently on-going is completed. The HSE is receiving some concern from cardholders who are subjected to more than one review in a short timeframe and this control may need to be reviewed in light of these public concerns.

\*\*\*\*\*

*22.4 The HSE expects the rate of non-response to reduce as a result of targeted review of cases where the cardholder has not received medical services for a significant period of time and cases where the HSE has evidence that the cardholder's circumstances have changed (using DSP and Revenue data).*

**HSE Update:** During the course of 2013, the PCRS has been getting enhanced data regarding re-instatement of eligibility. A re-instatement is a case where eligibility is put back in place during the course of the year where the person did not have eligibility on the 1 January in the year. Not every re-instatement results from loss of eligibility through non-response, e.g. re-instatement following appeal can be another issue, however in the main loss of eligibility through initial non-response is the main source of re-instatement cases. Re-instatement does occur all the way through the year and confirms the

likelihood that some persons will seek to re-establish eligibility when they need to access services rather than to adhere to HSE renewal procedures.

There were 58,310 cards re-instated during the course of 2013 with the following breakdown,

Medical Cards = 28,835

GP Visit Cards = 8,424

Medical Card Upgrades from GP Visit = 8,969

GP Visit Card Downgrades from Medical Cards = 12,082.

There are other factors affecting the rate of non-response including the level to which renewals are targeted. As targeting gets more and more effective and a bigger proportion of the renewals initiated then the rate of non-response will be impacted on this basis.

\*\*\*\*\*

## ***22.5 The HSE agrees that enhanced intelligence in relation to the reasons for the loss of eligibility could be used to inform additional controls that may be of benefit***

**HSE Update:** The HSE has continued to enhance its use of Revenue data in risk analysis and renewal targeting. In addition, early in 2014, the HSE wrote to Revenue seeking additional intelligence and this has resulted in the upgrading of the Revenue interface. This upgrade, which is currently being tested, also provides the HSE with the details of cases where Revenue deems there is "No Net Liability". The HSE is working with Revenue to ensure a proper understanding of cases where Revenue data can be relied upon to effectively confirm medical card eligibility.

The HSE continues to work on the integration of DSP data records. As of April 2013, data has begun to be shared. The Secretary General of the Department of Social Protection has appointed a senior official to work with the HSE to make progress in terms of this data delivery and a regular steering meeting is in place.

\*\*\*\*\*

## ***22.6 The HSE has conducted a random review in 2013 and intends completing random reviews on an annual basis.***

**HSE Update:** The random review procedure for 2014 has not been initiated at this point with the emphasis on Medical Card Plan 2014 to deal with the change in guidelines specified in Budget 2014 and to increase the level of reviews. The HSE is receiving some concern from cardholders who are subjected to more than one review in a short timeframe. Genuine random reviews will exacerbate the perception of "harassment" and this control may need to be reviewed in light of these concerns.

**John Hennessy**  
**National Director**  
**Primary Care**

**June 2014**





Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

**Report to**  
**Committee of Public Accounts**  
**On the 12 June 2014**

Revision: 1-0  
Date: 27-05-2014



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## 1 Introduction

The Primary Care Schemes are the means through which the health system delivers a significant proportion of primary care to the general public. Scheme services are delivered by Primary Care Contractors e.g. General Practitioners, Pharmacists, Dentists and Optometrists / Ophthalmologists.

Services are provided to 3.4m people in the community through 7,007 Primary Care Contractors. The Primary Care Schemes include:

- **General Medical Services (GMS) – Medical Card Scheme including GP Visit Cards**
- **Drug Payment Scheme**
- **Long Term Illness Scheme**
- **Dental Treatment Services Scheme (DTSS)**
- **High Tech Drug Arrangements**
- **Primary Childhood Immunisation Scheme**
- **Community Ophthalmic Scheme**
- **Services under Health (Amendment) Act 1996**
- **Methadone Treatment Service**
- **Immunisation (including influenza) for eligible persons**
- **European Health Insurance Card**

The Primary Care Reimbursement Service is now part of the Primary Care Division.

### 1.1 PCRS Key Priorities with Actions to Deliver in 2014

- The first phase of the introduction of a **universal GP service** in Ireland will commence during 2014. This will make available a GP service, without fees, to approximately 420,000 children aged 5 years and under. By the end of 2014, approximately one-half of the national population will have access to GP services without fees at the point of use.
- Implement revised **Guidelines** for Medical Cards and GP Visit Cards for persons aged 70 and over.
- Implement **new arrangements** for the retention of Medical / GP Cards for persons returning to work.
- Implement the revised **prescription charge** arrangements.
- Assess the **eligibility** of new applicants and review the eligibility of existing cardholders in line with health policy, regulations and the service level arrangements governing the administration of the GMS Scheme.



- Reimburse **primary care contractors** in line with health policy, regulations and the service level arrangements governing the administration of the Schemes.
- Progress a number of **key projects** to support the strategic priorities of the organisation as follows:
  - Drug Reference Pricing / Generic Substitution: Implement drug reference pricing and generic substitution to include determining appropriate reference prices.
  - Medicines Management Programme: Promote more cost effective prescribing by GPs and implement improved GP access to analysis of prescribing patterns.
  - Revenue and Department of Social Protection Interface: Develop greater integration of Revenue and Department of Social Protection data with PCRS database.
- Implement probity measures which will include:
  - Focusing on eligibility for services to ensure that those who are eligible to access services under the schemes continue to do so. In this regard, reviews of eligibility will be conducted in a risk-assessed manner in relation to approximately one million medical card holders during 2014.
  - Enhancing data sharing arrangements with both the Revenue Commissioners and the Department of Social Protection.
  - Focusing on review of claims for services from primary care contractors to ensure the reasonableness and accuracy of such claims.
  - Increasing the use of data analytics to support inspection functions.

## 1.2 Summary of Service Quantum

The following is a summary of expected levels of service in 2014. Access to medical services under the primary care schemes is provided primarily by legislation and policy embodied in a set of national guidelines.

PCRS is committed to providing access to medical services in a way which:

- Is aligned correctly with policy and all relevant legislation
- Provides a service experience to all stakeholders that exemplifies excellent customer service
- Improves the response times of all relevant processes involved in service delivery
- Is cost effective

The planned level of service for Schemes activity in 2014 is as follows:

- The number of *GMS prescriptions* - 21,639,388
- The number of *Long Term Illness* claims - 944,288
- The number of *Drug Payment Scheme* claims - 2,512,529
- The number of *High Tech* claims - 531,607
- The number of *Dental Treatments* (DTSS) provided – 1,354,079
- The number of *Community Ophthalmic Treatments* provided - 845,715



## 2 Medical Cards.

This report provides an update on the assessment of eligibility for Medical Cards for the Public Accounts Committee on 12 June 2014.

The HSE continues to make progress on the re-configuration of this key component of our national health infrastructure.

In this report we focus on six main areas:

- Medical Cards - General
- Medical Cards where discretion was involved in the assessment process
- The provision of a medical card in an emergency
- Medical Cards and specific medical conditions
- Probity and Control

## 3 Medical Cards - General

The HSE continues to provide a wide range of primary care services across the 12 community health schemes, including the Medical Card Scheme, to the entire Irish population. These services are commissioned by the HSE through over 7,007 Primary Care Contractors (i.e. Doctors, Pharmacists, Dentists etc), and involve approximately 80 million transactions each year successfully delivered to more than 3.4 million eligible persons. Planned expenditure this year in this element of primary care is approximately €2.4 billion.

Following concerns over many years, the HSE and the Department of Health decided that fundamental change in the administration of the schemes was required to ensure that the assessment of Medical Card eligibility would involve a standard, transparent, approach along with improved controls nationally and that higher levels of customer service and efficiency would be achieved. Therefore, it was decided to centralise the management of the medical card system. A major change programme was initiated, planned and rolled out by the HSE which culminated in the centralisation of Medical Card eligibility assessment processing on the 1 July 2011.

The Medical Card centralisation project has been successfully delivered. Medical Card processing is now carried out with single national governance and a central office location - compared with the 100 different locations. Customer service processes, assessment of applications and reviews, correspondence and the application of discretion are now operated effectively in a standard manner across the country.

Turnaround performance in processing Medical Cards is transparently reported online each week. The HSE continues to surpass the turnaround target of 90% processed at 15 days, e.g. as of 1 May 2014, over 92% of complete applications were processed at 15 days. See Appendix 3 in this document.



The vast majority of cardholders are satisfied with the service provided to them. There are currently 1,925,342 Medical and GP Visit Cards in circulation. This means that 42% of the Irish population have Medical Cards or GP Visit Cards.

In parallel with the focus on improvements in customer service and efficiency, the HSE is also focussed on its public accountability role in relation to the overall management of the Medical Card Scheme. Legislation passed in March 2013 created the legal basis for sharing of records with Revenue and the Department of Social Protection (DSP). This now allows for further improvements in the management of the Medical Card Scheme and offers an additional assurance that Medical Card eligibility continues to be provided to people appropriately in line with the national assessment guidelines for eligibility.

### 3.1 Eligibility

Eligibility for a Medical Card or a GP Visit Card is determined on the basis of an assessment of financial means. Although we have streamlined the process and continue to work to make it simpler and more efficient we recognise that it can be challenging for some applicants. Therefore, if an applicant received a notification that their application was not successful, the process also provides applicants with an opportunity to provide any additional information that they may not have provided initially, and all of this material is reviewed and considered as part of the application process. The processes through which Medical Cards are provided are specified in detail in Appendix 1 in this document.

The HSE can also provide a medical card in emergency circumstances to patients in urgent need of medical care that they cannot afford. More details are set out in Section 3 below.

Certain persons are automatically entitled to a Medical Card, such as those with a European Union entitlement and those who are entitled to retain their Medical Card under certain government schemes.

## 4 Medical Cards where discretion was involved in the assessment process

Under the Health Act 1970, assessment of eligibility for a medical card is determined primarily by reference to the means, including the income and expenditure, of the applicant and his or her partner and dependants.

While people with specific illnesses or conditions are not automatically entitled to medical cards, the HSE examines for any indication of circumstances that which might mean that a person cannot access General Practitioner or other medical services, without undue financial hardship. In such circumstances the HSE can apply discretion and grant a medical card where a person's income exceeds the income guidelines. There can be a significant crossover between social and medical circumstances and applications do not fall discretely into these specific categories. The process where the application of discretion may be considered includes a review by HSE Medical Officers.



It is also important to note that persons with certain long-term conditions may register under the Long Term Illness Scheme. Under this scheme they are entitled to drugs, medicines, and medical and surgical appliances directly related to the treatment of their condition, free of charge. It does not depend on their income or other circumstances and is separate from the Medical Card Scheme and the GP Visit Card Scheme.

The policy for assessing eligibility for Medical Cards and GP Visit Cards has not changed with the centralisation of Medical Card processing. Medical cards are assessed in accordance with the governing legislation and in a uniform and consistent manner throughout the country.

The medical card system is founded on the "undue hardship" test. The Health Act 1970 provides for medical cards on the basis of means. That is what the law states and the HSE must operate within the legal parameters and within these parameters works to ensure that the system responds to the variety of circumstances and complexities faced by individuals who apply for a medical card.

#### **Analysis from 1 Jan 2013 to date, of Medical Cards where discretion was involved in the assessment process**

- On 1 January 2013 - 78,959 people had eligibility where discretion was involved in the assessment process. 15,833 of these had a GP visit card and 63,126 had a medical card.
- On 1 April 2014 - 78,676 people had eligibility where discretion was involved in the assessment process. 29,080 of these had a GP visit card and 49,596 had a medical card.
- Of those people who had eligibility where discretion was involved in the assessment process on 1 January 2013 - 61,571 (78%) still have eligibility in April 2014, where discretion was involved in the assessment process. 15,036 have GP Visit Card eligibility and 46,535 have Medical Card eligibility.

As of April 2014, 17,388 people who held eligibility on 1 January 2013 have lost eligibility. The analysis of these cases is as follows;

- 1,327 have passed away
- 7,886 did not respond to review correspondence. 4,971 did not respond at all, the balance responded initially but then did not provide the material required to successfully establish eligibility
- 930 have been requested to provide additional information or their case is still being assessed
- 5,860 have been deemed unsuccessful because the eligibility criteria was not met
- 1,385 lost eligibility but in circumstances where other family members were provided with eligibility



In relation to the 5,860 people deemed to be unsuccessful because the eligibility criteria were not met; these were associated with 4,235 medical card (family) applications. The threshold and income for 4,058 of these family applications is available to report. The following table applies to those cases and analyses the gap between the cases concerned and the income guidelines.

Percentage Guidelines	Above	Number	Weekly Income Above Guidelines	Number
200% or More		512 (13%)	€500 or more per week	1,090 (27%)
50% - 200%		3,200 (79%)	€250 to €500 per week	2,049 (50%)
Up to 50%		346 (8%)	Up to €250 per week	919 (23%)
		4,058 (100%)		4,058 (100%)

One of the consequences of the transition to a national system has been difficulty at renewal stage for higher income households - even where serious illness or disability is involved. This issue is being addressed in a manner that includes all of the services and supports provided by the HSE with as much flexibility as is available and at a local level.

Improved published information and local information points are being established at major health centres around the country, where members of the public can obtain comprehensive information and support in accessing their full range of supports and entitlements from the Health Services.

In the meantime, the exercise of discretion in relation to medical card assessment is also being reviewed at present. The objective is to maximise the supports available for patients and families. Appropriate notice is also being considered as part of this review for existing medical card holders who may no longer be eligible on renewal - but where serious medical conditions or profound disability continues to exist in the household.

## 5 The provision of a Medical Card in an Emergency

In certain circumstances, the HSE can provide Medical Cards in emergency circumstances to patients that are in urgent need of medical care that they cannot afford. Medical Cards can be issued in Emergency circumstances, within 24 hours of receipt of the required patient details and letter of confirmation of condition from a doctor or consultant.

Medical Cards issued due to an Emergency are generally requested by a manager in a Local Health Office or a Social Worker.

A Medical Card can be requested, in response to an emergency situation in respect of:

- A person in palliative care, who is terminally ill
- A homeless person in need of urgent or on-going medical care
- A person with a serious medical condition in need of urgent or on-going medical care
- A foster child in need of urgent or on-going medical care
- An asylum seeker with a serious medical condition in need of urgent or on-going medical care



A Medical Card issued in an Emergency can only be issued to an individual named person, i.e. no dependants will be included unless a case is made separately for any other member of the family on medical emergency grounds.

Where a Doctor or a Consultant certifies that there is a terminal illness and the applicant is nearing the end stage of life, the nature of the terminal illness is not a deciding factor in the issue of a medical card in these circumstances and no means test applies. The HSE monitors such cases and can renew the clients' eligibility if necessary. In such circumstances there is no assessment of means.

With the exception of terminally ill patients, all cards issued in these circumstances are issued on the basis that the patient is eligible for a Medical Card based on the financial threshold applicable to their particular individual or family means or on the basis of undue financial hardship, and the patient will follow up with a full application within a number of weeks of receiving the emergency card.

Where it is necessary to issue a Medical Card in an emergency situation to a named individual, the cards is issued for a period of six months. The process is:

1. As much information about the person (as would be asked on the standard application form) should be gathered and provided, but as a minimum the following details are required: The person's Name, Address, DOB, PPSN and Doctor of Choice
2. A clear note setting out the emergency situation that exists and the reason why an emergency card is being requested should also be provided.
3. The details above should be faxed or emailed to PCRS by a manager in the local office, or Social Worker, along with any documentary evidence, e.g. letter from consultant confirming the patient condition.
4. Following the issue of a Medical Card due to an emergency situation the patient should complete an application form in full, with the assistance of the local health office if necessary, and send it to the central office in PCRS within four weeks along with all of the normal documentary evidence required to assess eligibility, and a cover note.

It can take a day to physically produce the plastic card and a further day in the post but the Medical Card number can be provided to the local office or Social Worker within 24 hours if requested. Once approved, any Primary Care Contractor can validate the entitlement of a customer through the online system.

## **6 Medical Cards and Specific Medical Conditions**

As set out above, under the Health Act 1970 assessment for a medical card is determined primarily by reference to the means, including the income and expenditure, of the applicant and his or her partner and dependants.

However, if an applicant's means are above the financial thresholds the HSE examines for any indication of circumstances that might result in undue financial hardship and can apply discretion in the granting of medical cards, or GP visit cards. In such cases, a review of the medical or social



circumstances is undertaken by a Medical Officer, who makes a recommendation on the granting/refusal of eligibility to a Deciding Officer. The exercise of discretion is always undertaken against the background of particular challenging medical or social circumstances, which of their nature require subjective and sensitive consideration.

Persons with specific illnesses such as cancer, or conditions such as Down's syndrome, are not automatically entitled to medical cards and all new applicants and renewal applicants are dealt with on a case by case basis and under the qualifying rules and guidelines that are published and transparent.

The policy for assessing eligibility for Medical Cards and GP Visit Cards has not changed with the centralisation of Medical Card processing. Rather, assessment is conducted in an equitable and consistent manner nationally based on standard operating procedures. This ensures that people, with serious illness, with incomes within reasonable reach of the qualifying scales can qualify. However, this becomes progressively more difficult as incomes increase to multiples of the qualifying scale. It is important to correct any impression circulating that medical cards are issued 'automatically' or irrespective of means even if an applicant is suffering from a serious medical condition.

Unsuccessful applicants also have rights of review and appeal if they feel they have been unfairly treated or denied their entitlements.

It is important to note that Down's syndrome is covered under the Long Term Illness Scheme, for which entitlement applies irrespective of means. Where a person with Down Syndrome is not eligible for a medical card following an assessment of their means the HSE can provide their full requirements in respect of prescribed medicines and appliances free of charge through this statutory entitlement. In addition, Hospital care is provided for all public patients in Ireland, with charges confined to attendance at the Emergency Department (A&E) if not referred by a GP and not admitted overnight. Outpatient care in a public hospital is free of charge for all public patients and the maximum charge for inpatient or day case care in a public hospital is €75 per day and capped at a maximum of €750 per annum. Public dental, ophthalmic and aural treatment and appliances are also available free of charge to children and in respect of any difficulties identified at child health or school health examinations.

Details of further services available to all patients under the Disabilities Act are available at local health centres.

#### **Long Term Illness Scheme.**

People with certain long-term illnesses or disabilities can register under the Long Term Illness Scheme. Under this scheme they are entitled to drugs, medicines, and medical and surgical appliances directly related to the treatment of their illness, free of charge. It does not depend on their income or other circumstances and is separate from the Medical Card Scheme and the GP Visit Card Scheme.

#### **Specified LTI Conditions:**

- Mental Handicap



- Hydrocephalus
- Cerebral Palsy
- Muscular Dystrophy
- Haemophilia
- Diabetes Mellitus
- Diabetes Insipidus
- Epilepsy
- Multiple Sclerosis
- Parkinsonism
- Cystic Fibrosis
- Phenylketonuria
- Acute Leukaemia
- Mental Illness (Under 16 years of age)
- Spina Bifida
- Conditions arising from the use of Thalidomide (All hold Medical Cards)

## 7 Probity and Control

The scale of costs within the Medical Card and Primary Care Schemes and the volume of transactions associated with them means that there are potential areas of risk that need to be managed. A critical element of probity in the Medical Card Scheme is the review of eligibility. This is undertaken in a number of ways:-

- A review upon expiration of the defined eligibility period (substantially 3 years)
- Risk based reviews based on specific criteria such as inactive cards or where information from other statutory bodies indicates that the medical card should be reviewed
- Random reviews
- Use of the Death Events Notification System (DEPS), which identifies people who are deceased and enables the cessation of capitation payments in cases where the GP / family have not already notified the HSE.

Each month, the HSE analyses the Medical Card Register to identify those Medical/GP Visit Cards which are scheduled for review within three months.

Legislation passed in March 2013 created the legal basis for sharing of records with Revenue and the Department of Social Protection (DSP). This now allows for further improvements in the management of the Medical Card Register and offers an additional assurance that Medical Card eligibility continues to be provided to people appropriately in line with the national assessment guidelines for eligibility. As soon as this information became available to the HSE in 2013 it was incorporated into the risk analysis process and it assisted with the determination of the review approach to adopt. The extent and quality of this information sharing for the purposes of control over medical card eligibility continues to develop.

Most medical cards are awarded for three years following eligibility assessment. However, eligibility may cease upon a change in circumstance and therefore a review of eligibility may be initiated during the eligibility period to confirm continuing eligibility.

At 1 January 2013 there were 1,853,877 medical cards in issue with an additional 131,102 GP visit cards. During 2013, there were 1,279,042 people with eligibility, which was scheduled to expire in monthly tranches. The full cohort in each monthly tranche which was approaching eligibility expiry was subject to a risk analysis to determine the review approach to adopt in each case. Renewal notices issued in relation to 600,741 people. Renewal notices were not issued to the remaining 678,301 persons as it was concluded on the basis of the risk assessment, which included data from the Revenue Commissioners, that those people were at low risk or at no risk of being ineligible and eligibility was extended for a further year. Renewal of a medical card can be done by way of a full review of eligibility by the HSE or by cardholder self-assessment depending on the relative risk identified during the risk assessment process. Of the 600,741 renewals issued in 2013, 283,764 involved a full review and 316,977 requested the cardholder to self-assess.

### ***Renewal Notice Reviews***

A renewal notice is a review initiated three months prior to the end of the eligibility period. During 2013 the HSE issued 600,741 renewal notices. As at 7 April 2014, the assessment of eligibility had been concluded in relation to 451,493 cardholders.

- Continuing eligibility was confirmed in relation to 428,958 cards (95.01%)
- 22,535 cards were not renewed (4.99%) because the eligibility criteria e.g. income thresholds were not met.

In a further 107,279 cases, medical cards were not renewed because the cardholder did not respond to the renewal process. The assessment of eligibility was on-going in relation to 33,909 cards and in 8,060 cases the cardholder was deceased.

### ***Targeted Reviews***

A review is "targeted" when it is initiated during the eligibility period rather than when a three month eligibility period is left. During 2013, the HSE issued 44,120 targeted reviews. As at 7 April 2014 the assessment of eligibility had been concluded in relation to 9,207 cardholders.

- Continuing eligibility was confirmed in relation to 6,921 cards (75.17%)
- 2,286 cards were not renewed (24.83%) because the eligibility criteria e.g. income thresholds were not met.

In a further 17,324 (39.3%) cases medical cards were not renewed because the cardholder did not respond to the renewal process. The assessment of eligibility was on-going in relation to 17,397 cards and in 192 cases the cardholder was deceased.

In summary, the total number of reviews initiated during 2013 was 644,861 including both renewal notice reviews and targeted reviews.



### **Residence Confirmation**

In addition to the review of eligibility outlined above, the HSE also uses risk assessment to determine when to seek confirmation of residence in the State in relation to inactive cards.

During 2013, 102,027 individuals whose medical cards had been inactive for periods of more than 12 months were contacted requesting residence confirmation. As at 28 February 2014, 75,684 individuals (74.2%) had confirmed residence. Eligibility was removed in relation to 25,403 cards (24.9%). 940 persons (0.9%) lost eligibility but have since been reinstated.

## **8 Support for Oireachtas Members**

### **8.1 Documentation**

In 2013, the HSEs Medical Card office handled 7.8 million items of documentation in the administration of the medical card scheme. 4.5 million items were incoming and 3.3 million items were outgoing. Throughout the year, the target to turnaround 90% of applications (where all the material required for assessment is provided) in 15 days was delivered successfully. The HSE is on course to significantly increase the level of review activity in 2014 and the incoming documentation will increase in line with this increased activity. The turnaround performance is published online each week at [www.MedicalCard.ie](http://www.MedicalCard.ie) and the latest report is attached to this document.

As of April 2014, a significant human effort is still involved in handling a large volume of documentation and it is inevitable that there are some issues with documentation.

However, there is little evidence to suggest that the extent of the problem is material or out of line with that which would be expected given the scale of documentation handled.

### **8.2 Oireachtas Line**

There is an increased level of review activity in 2014 and in particular is likely related to the implementation of the changed guidelines for the cohort 70 years and over which commenced in terms of reviews initiated in March and April 2014. This component of the review programme is likely to continue in terms of processing incoming review material through July 2014.

The tables below show the increase in activity on the Oireachtas line and also on the Medical Card line in March and April 2014.

<b>Oireachtas Line Activity Jan – April 2014</b>				
	<b>Jan-14</b>	<b>Feb-14</b>	<b>Mar-14</b>	<b>Apr-14</b>
Calls Incoming	1,895	1,916	2,025	2,568
% increase from previous month	41%	1%	6%	27%
Calls Answered	1,854	1,868	1,986	2,526

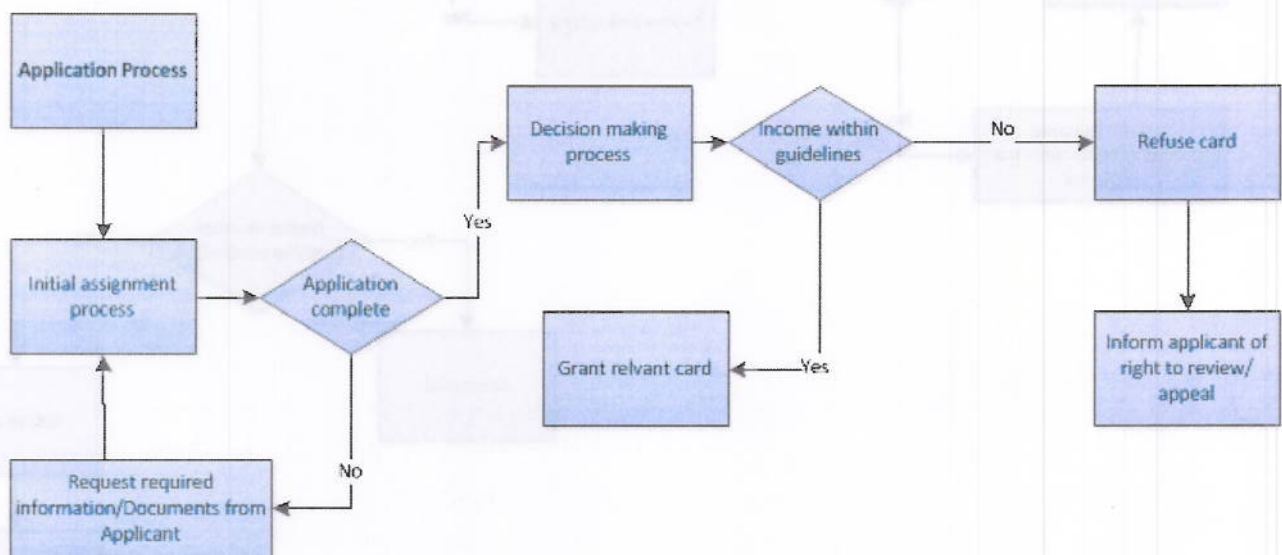


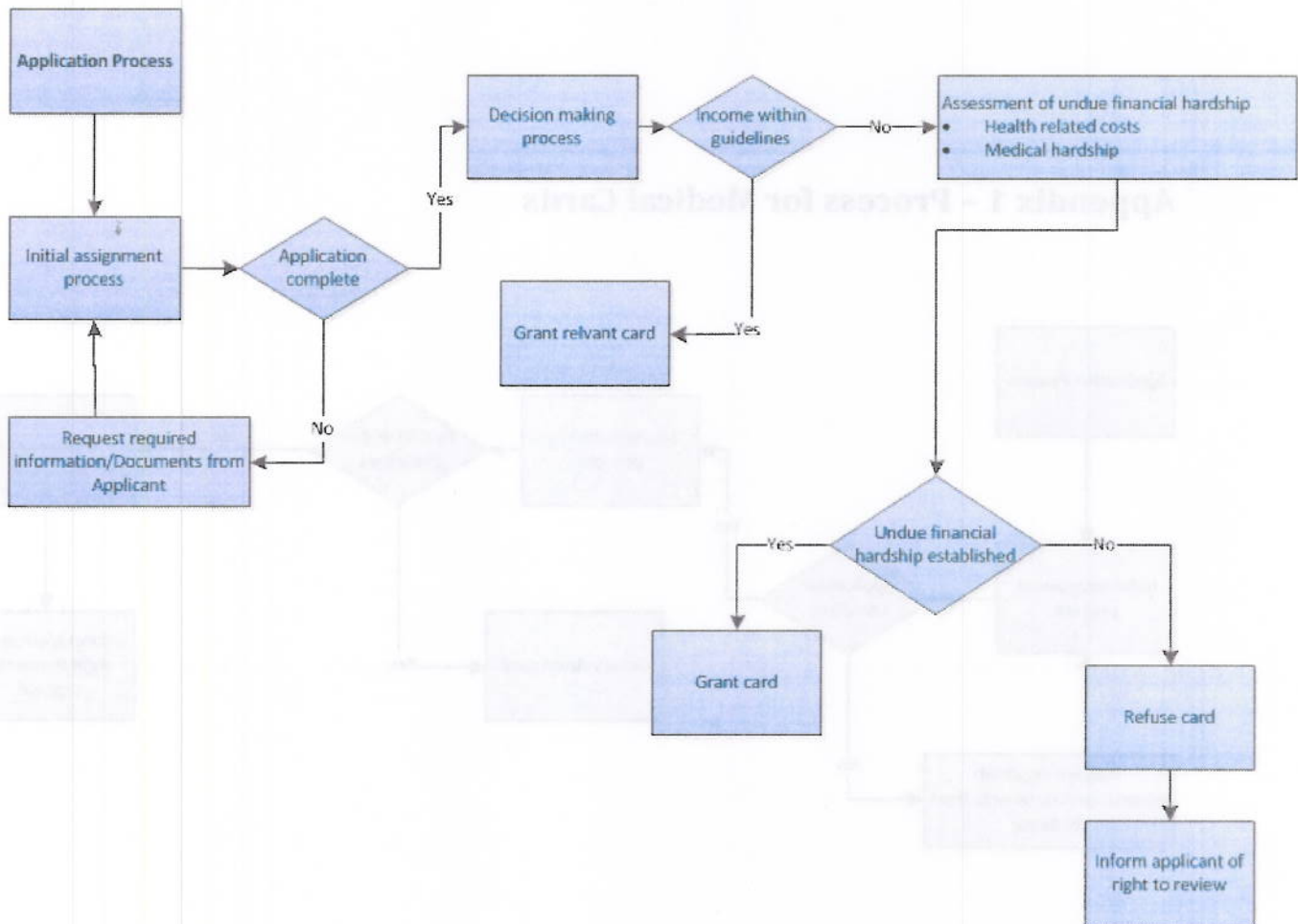
Abandon rate	2%	3%	2%	2%
Answer rate	98%	97%	98%	98%
No. of customer service agents	4	4	5	5
No. of Supervisors	1	1	1	1
	<b>Jan-14</b>	<b>Feb-14</b>	<b>Mar-14</b>	<b>Apr-14</b>
Emails	1302	1312	1019	1935
% increase/decrease from previous month	13%	1%	-22%	90%

<b>Medical Card Line Activity Jan – April 2014</b>				
	<b>Jan-14</b>	<b>Feb-14</b>	<b>Mar-14</b>	<b>Apr-14</b>
Calls Offered	78787	62710	69890	84934
% increase from previous month	89%	-20%	11%	22%
Calls Answered	48880	50342	62879	78205
Abandon rate	38%	20%	10%	8%
Answer rate	62%	80%	90%	92%
No. of customer service agents	68	72	87	107
No. of Supervisors	4	4	4	6
	<b>Jan-14</b>	<b>Feb-14</b>	<b>Mar-14</b>	<b>Apr-14</b>
Emails	8781	8330	7673	6989
% increase/decrease from previous month	88%	-5%	-8%	-9%

Continued efforts are made on an ongoing basis to balance the requirements to provide a speedy answer and response rate to enquiries, and deal with applications, reviews and all of the associated work, taking account of the increases workload in a resource constrained environment.

## Appendix 1 – Process for Medical Cards

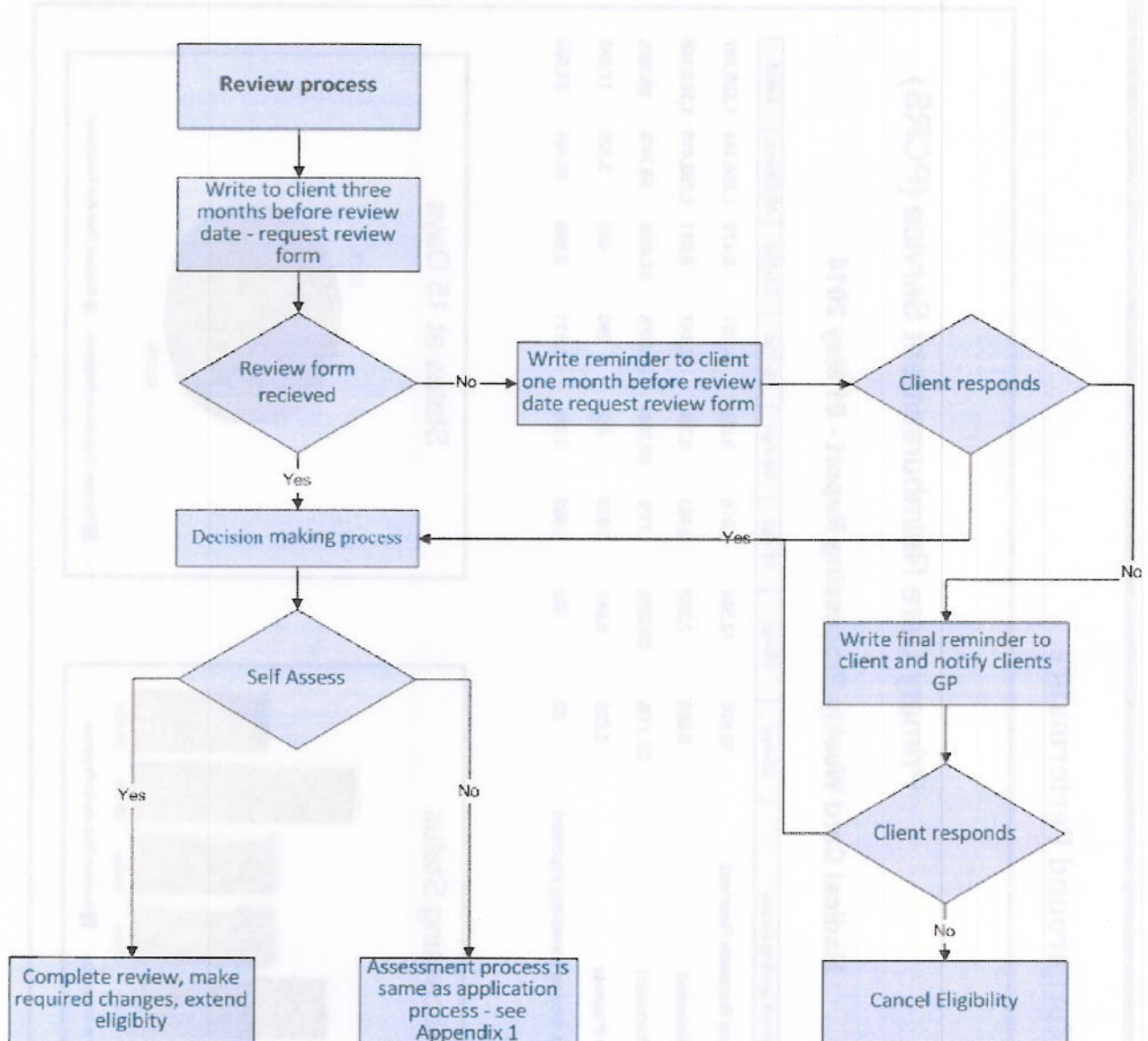


**Process where discretion is applied in the assessment of eligibility**



## Appendix 2 – Process for Medical Card Reviews

### Appendix 2



## Appendix 3 – Medical Card Turnaround Performance

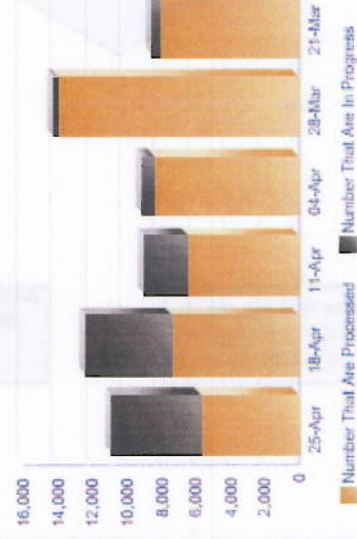


## Primary Care Reimbursement Service (PCRS)

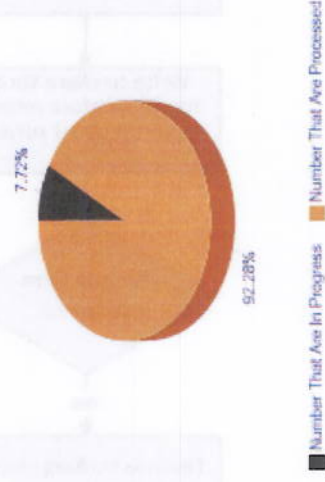
## Medical Card Weekly Processing Report - 01 May 2014

Status Week ending Friday	25-Apr	18-Apr	11-Apr	04-Apr	28-Mar	21-Mar	All Others	Total
Total Applications and Renewals Received	10,876	12,385	9,018	9,058	14,227	8,479	1,256,744	1,320,787
Number That Are Processed	5,668	7,338	6,403	8,359	13,947	8,011	1,253,419	1,303,145
% That Are Processed	52.11%	59.25%	71%	92.28%	98.03%	94.48%	99.74%	98.66%
Number That Are In Progress	5,208	5,047	2,615	699	280	468	3,325	17,642
Applications that are missing something important	53	352	1,930	2,285	3,111	3,593	10,484	21,808

Processing Status



Status at 15 Days



**Briefing Paper for the Public Account Committee Meeting  
12<sup>th</sup> June 2014**

**On progress with the Section 38 Agencies reaching compliance  
with Government Pay Policy**

**Background**

The process that has been on going with Section 38 Agencies to reach compliance with Government Pay Policy is nearing completion. Since the beginning of the year the

**Briefing Paper for the Public Account Committee Meeting  
12<sup>th</sup> June 2014**

**On progress with the Section 38 Agencies reaching compliance  
with Government Pay Policy**

In line with the pay policy, organisations seeking to make a business case for the construction of an unapproved allowance were invited to submit business cases for consideration by the HSE. Business cases were also required for the continued payment of allowances which are not encompassed by or in line with the Department of Health Consolidated Salary Scales but may have been sanctioned in the past. In this regard a total of 202 business cases were received.

Of the 202 business cases received, 59 were in respect of salary level below Grade VIII and these cases were reviewed at operational level by the Regional Director of Performance and Integration with support from Regional HR.

**Internal Review Panel Process**

143 business cases were received in respect of Senior Managers i.e. those at salary level of Grade VII and above and these were reviewed in detail by an Internal Review Panel, consisting of nominated members of the HSE Leadership Team. A report on the Panel's deliberations issued to each Agency on 8<sup>th</sup> April 2014.



**Briefing Paper for the Public Account Committee Meeting  
12<sup>th</sup> June 2014**

**On progress with the Section 38 Agencies reaching compliance  
with Government Pay Policy**

**Background**

The process that has been on going with Section 38 Agencies to reach compliance with Government Pay Policy is nearing completion. Since the beginning of the year the Regional Directors of Performance and Integration (RDPI's), with support from Regional HR, have been working with each Agency through a further process of verification and clarification where non compliance with pay policy was previously recorded to ensure the full implementation of the provisions of the pay policy to assist Agencies reaching compliance.

In line with the pay policy, organisations seeking to make a business case for the continuation of an unapproved allowance were invited to submit business cases for consideration by the HSE. Business cases were also required for the continued payment of allowances which are not encompassed by or in line with the Department of Health Consolidated Salary Scales but may have been sanctioned in the past. In this regard a total of 202 business cases were received.

Of the 202 business cases received, 59 were in respect of salary level below Grade VIII and these cases were reviewed at operational level by the Regional Directors of Performance and Integration with support from Regional HR.

**Internal Review Panel Process**

143 business cases were received in respect of Senior Managers i.e. those at salary level of Grade VIII and above and these were reviewed in detail by an Internal Review Panel, comprising of nominated members of the HSE Leadership Team. A report on the Panel's deliberations issued to each Agency on 8<sup>th</sup> April 2014.

This report provided details on the criteria the Panel used when assessing the merits of each business case; a narrative on the decisions made; the decision made in each case; and information on some legal considerations to assist the Agencies when making arrangements to cease the payment of unapproved remuneration.

In addition the Panel in their report made the following two key recommendations:

1. A process to review the appointment of Clinical Directors throughout the health services should be conducted under the auspice of the National Director of Acute Hospitals in consultation with the Hospital Group Chief Executive Officers' and the Chief Clinical Directors in each Hospital Group.
2. A further review/sizing of the remuneration rates of CEO's and Senior Management in Agencies identified in the report should be undertaken to ensure the pay rates reflect the comparable size, scale and complexity of each organisation. Approval to progress this recommendation has been sought from Department of Public Expenditure and Reform by the Department of Health and a decision is awaited.

A copy of the full report from the Internal Review Panel, which was previously provided to the Committee in mid-April 2014, is attached for the information of members.

Agencies were advised that it is their responsibility as the direct employer to implement the recommendations made. A period of up to three months to 1<sup>st</sup> July 2014 was provided to allow each Agency to make the necessary arrangements to cease the payment of all unapproved remuneration and to ensure appropriate risk mitigation measures were put in place to deal with issues as they arise. Each Agency was requested to respond to the HSE by 16<sup>th</sup> May 2014 setting out their intended course of action.







Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

## **Report of the Internal Review Panel into Business Cases received from Section 38 Agencies to reach compliance with Government Pay Policy**

### **1. Background**

In June 2012 the HSE Internal Audit (IA) undertook a review of the remuneration paid by Section 38 agencies (being bodies funded by the HSE pursuant to Section 38 of the Health Act 2004) to their senior management. The audit identified significant key findings and the overall assessment of the control environment was considered to be seriously inadequate due to the significance of the issues identified.

The Internal Audit report, which was presented at a meeting of the HSE Board on 23<sup>rd</sup> July 2013, made twenty-two recommendations to address the issues. HSE management unreservedly accepted the recommendations and immediately set about actioning the recommendations in conjunction with the Department of Health.

In response to a number of the recommendations contained in the audit report on 27<sup>th</sup> September 2013 the Department of Health, following consultation with the Department of Public Expenditure and Reform, issued Circular 11/2013 on compliance with health sector pay policy as it applies to the health services and in particular to those bodies funded by the HSE in whole or in part pursuant to Section 38 of the Health Act 2004. The Circular reflects Government policy on public service pay. The policy makes it clear that bodies funded under Section 38 of the Health Act 2004 shall not pay nor subsidise salaries, expenses or other perquisites which exceed those normally paid within the public sector and may not supplement approved rates of remuneration with either Exchequer funding or non-Exchequer sources of funding. The Circular confirmed the position already iterated by the HSE in its Section 38 agreements with the relevant agencies.

The Department of Health Circular was issued to the health sector by the National Director of Human Resources by way of HSE HR Circular 016/2013 on 30<sup>th</sup> September 2013, (attached in Appendix I). This communication issued to the CEO's of the Section 38 Agencies, which included a copy of the audit report, and sought confirmation of compliance with the terms of the Department of Health Circular.



Agencies were requested to confirm their unequivocal confirmation of compliance by 28<sup>th</sup> October 2013. A process of engagement between the Agencies and the National HR Office was progressed throughout November 2013 in working to reach compliance.

## **2. Regional Directors of Performance and Integration Verification Process**

In December 2013 the Regional Directors of Performance and Integration (RDPI's), with support from Regional HR, worked with each Agency through a further process of verification and clarification where deviance from the pay policy was previously recorded to ensure the full implementation of the provisions of the pay policy and to assist the Agencies in reaching compliance.

In line with the pay policy, and as part of the ongoing process to reach compliance, organisations seeking to make a business case for the continuation of an unapproved allowance were invited to submit their business cases for consideration by the HSE. Business cases were also required for the continued payment of allowances which are not encompassed by or in line with the Department of Health Consolidated Salary Scales but may have been sanctioned in the past. A total of 202 business cases were received.

## **3. Internal Review Panel Process**

In March 2014, an Internal Review Panel, comprising of nominated members of the HSE Leadership Team, reviewed each business case in detail. The membership of the Panel included: Ms Laverne McGuinness, Chief Operating Officer/Deputy Director General; Mr Pat Healy, National Director of Social Care; Mr Ian Carter, National Director of Acute Hospitals; and Mr Barry O'Brien, National Director of Human Resources.

143 business cases were received in respect of Senior Managers i.e. those at salary level of Grade VIII and above for consideration by the Internal Review Panel. In addition, 59 business cases in respect of salary level below Grade VIII were reviewed and dealt with at operational level by the Regional Directors of Performance and Integration with support from Regional HR.

**3.1 The criteria used when assessing the merits of each business case was based on the following key principles:**

- Any allowance or perquisite which is not encompassed by, or in line with the Department of Health Consolidated Salary Scales, and which has not previously been sanctioned in writing by the Minister for Health, with the consent of the Minister for Public Expenditure and Reform, must cease with immediate effect
- Agencies shall not pay nor subsidise salaries, expenses or other perquisites which exceed those normally paid within the public sector
- Agencies must adhere to the consolidated salary scales where they apply and are not authorised to pay salaries in excess of the Department of Health Consolidated Salary Scales for approved grades
- Only allowances included in the Consolidated Salary Scales may be paid. These must be paid in respect of the duties and grades specified
- The approval of the Department of Health will be required where a proposed allowance is not encompassed by existing rules
- Any allowance considered for sanction should be time-bound and subject to review within a specified period
- In accordance with the *one person one salary principle* serving public servants require the consent of the Department of Public Expenditure and Reform in order to undertake other forms of paid remuneration in any part of the public service

**3.2 Decisions on business cases**

3.2.1 All business cases in respect of Senior Managers have been reviewed and decisions made by the Internal Review Panel are outlined in the attached document, *Decisions on Business Cases Reviewed by the Internal Review Panel*, Appendix II. In implementing the decisions made health service employers should reference the points outlined below and refer to the legal considerations provided in Section 4 of this report.

3.2.2 In considering the implications of recommending allowances to cease, the Internal Review Panel have set a period of up to three months to 1<sup>st</sup> July 2014 to allow sufficient time for Agencies to make the necessary arrangements to cease the payment of all unapproved remuneration and to ensure appropriate risk mitigation measures are put in place to deal with issues as they arise.



3.2.3 In line with Recommendation No. 20 of the IA Report, a review of the remuneration rates of CEO's and Senior Management of Agencies identified as requiring review / sizing, particularly in the Social Care Division, should be undertaken to ensure the pay rates reflect the comparable size, scale and complexity of each organisation. This review should be undertaken by the HSE in consultation with the Department of Health

3.2.4 In line with Recommendation No. 22 in the IA Report, all future appointments to CEO or Senior Management posts in Section 38 funded agencies should be subject to specific sanction to approve the entirety of the remuneration package and no deviations should be subsequently allowed without formal approval by the HSE in consultation with the Department of Health. In addition the new Annual Compliance Statement introduced in December 2013 to enhance the overall governance framework between the HSE and the Section 38 agencies it funds, together with the annual Service Agreement, should provide a further control mechanism to ensure only approved salaries are paid.

3.2.5 *Future Health: A Strategic Framework for Reform of the Health Service 2012 - 2015* provides an overarching policy framework for the establishment of Hospital Groups. The management structure and the process to implement Hospital Groups as a transition to Independent Trusts has been set out in the Higgins Report. The changes necessary in our hospital system to achieve the goals set for the Hospital Groups will require significant change in the governance and management structure across the hospitals in the Group. Each Group will have a Chief Clinical Director (CCD) who will have overall responsibility for delivery of clinical services within the Group and all individual Clinical Directors will report to the CCD.

In reviewing business cases received in respect of additional remuneration / allowances for Consultants / Clinicians, not in line with the Consultants Contract or the Department of Health Consolidated Salary Scales, it has been decided that these allowances are not appropriate and should cease to be paid in line with the time frame set out in this report. In addition it is recommended that, to ensure continued patient safety and quality of service delivery, as a matter of priority in the period available up to 1<sup>st</sup> July 2014, a process to review the appointment of Clinical Directors throughout the health service is conducted under the auspice of the National Director of Acute Hospitals in consultation with the Hospital Group Chief Executive Officers' and the Chief Clinical Directors in each Hospital Group.

3.2.6 Where an allowance or payment has been identified as appropriate under the *one person one salary principle* then sanction to approve such an arrangement must be sought immediately from the Department of Health and the Department of Public Expenditure and Reform in line with Section 5 of the pay policy.

#### **4. Legal Considerations**

The Internal Review Panel is cognisant of the fact that the HSE is not the employer of the individuals in receipt of the allowances under consideration. It is therefore appropriate for the employer, not the HSE or the Department of Health, to take ownership of implementation of the decisions made by the Internal Review Panel.

In guiding the Agencies to deal with the cessation of unapproved remuneration the Internal Review Panel has noted the following approaches might be considered.

#### **4.1 The principal ways in which allowances being paid to individual recipients might be removed are:**

- 4.1.1 Obtaining the agreement of the receiving employee to the cessation of the unapproved allowance.
- 4.1.2 If the allowance in question is not contractual and is genuinely discretionary;
- 4.1.3 If the allowance in question is subject to specific terms and conditions e.g. terms that dictate a defined period of time over which the allowance is payable, or an express right of the employer to remove or cease the allowance, the exercise of same should be explored;
- 4.1.4 If the allowance related to a specific duty or obligation or equivalent that is no longer carried out or required, the allowance might legitimately be defunct and the employer entitled to cease paying it;
- 4.1.5 Implementing a more direct change such as:
  - a) Imposing the change (i.e. rejecting the “offending” allowance/contractual term and offering continued employment on precisely the same terms and conditions of employment, with full recognition of service to date, but with the offending allowance/provision excised from the contract/employment relationship, with a view



to securing the employee's acceptance of the change or , or achieving another form of compromise with the employee; or

- b) Terminating the "offending" contract and offering immediate reengagement on precisely the same terms and condition of employment, with full recognition of service to date, but with the offending allowance excised from the employment relationship.

The Internal Review Panel would expect each employer to take advice prior to implementing such changes so that it does so in a legally compliant manner and/or mitigating risk to the greatest extent possible.

#### **4.2 Promotion or new working arrangements for current employees**

In making a new offer of employment, either through promotion or revised working conditions, it should be a condition of any such offer that the employee accepts remuneration in conformity with the consolidated pay scales, thereby removing any unapproved allowance. In circumstances where the allowance in question was paid to a previous holder of the post in question, the employee might contend the situation is unfair relative to his/her predecessor, however no legitimate claim to such unapproved allowance can arise as (a) the allowance in question was unauthorised and (b) acceptance of the offer of the new/revised post by the employee in question is strictly voluntary. It is important throughout that the employer make it abundantly clear that the difference in terms relates to the removal of an unauthorised allowance and, for example, is not grounded on a prohibited ground such as the nine discriminatory grounds set out in the Employment Equality Acts.

#### **4.3 New employees/recipients**

There is no reason why the historic practice of paying a particular unauthorised allowance to an individual manager/post requires that practice to be continued for future appointees and the practice (if it arises) should cease immediately.

## Decisions on Business Cases reviewed by Internal Review Group

Agency	Compliance issue to be addressed (Details provided by Grade title, allowance and salary paid)	Summary of Business Case made	Internal Review Group decision
Adelaide & Meath Hospital incorporating the National Children's Hospital, Tallaght	<b>Deputy CEO</b> allowance 33,250 Salary 85,407-103,943	Business case for continuation until October 2014.	Cease
	<b>Associate Medical Consultant</b> personal to holder salary - 161,131	Business case for retention on a personal to holder basis (non Consultant service grade)	Cease
	<b>Director of Quality &amp; Risk</b> -on call allowance 10,757 Consultant Category A	Business case to continue until completion of contract in February 2017	Cease
	Lead Clinician in Radiology – 22,788	Business case to continue payment until service reconfiguration in context of hospital groups	Cease
	Medical Board Chairperson – 2,098 per month (25,176 per p.a.)	Business case to continue payment until service reconfiguration in context of hospital groups	Cease
	<b>CEO</b> Salary – 136,282 Lecturing allowance from RCSI - 20,000	Letter confirming that this is under a separate contract of employment (time commitment is additional to contractual commitment to Beaumont)	One person one salary principle – requires Departmental approval
	<b>Deputy CEO/Head of Strategy</b> - Allowance 18,478 Salary 85,407-103,943	Business case to regularise post holder on Hospital Network Manager Scale on a personal to holder basis (contractual obligations exist).	Cease
	<b>Director of HR</b> - 7,083 allowance Salary Functional Officer (non EHB) 65,376-79,481	Business case to upgrade post to Assistant National Director level in line with comparators in other DATHs. (contractual obligations exist).	Cease
	<b>Academic Health Centre Project Manager</b> – 7,053 allowance Salary Functional Officer (non EHB) 65,376-79,481	Business case to regularise post holder on Deputy General Manager, Regional Hospitals Scale on a personal to holder basis (contractual obligations exist). (79,304-95,972)	Cease



## Decisions on Business Cases reviewed by Internal Review Group

Agency	Compliance issue to be addressed  (Details provided by Grade title, allowance and salary paid)	Summary of Business Case made	Internal Review Group decision
	<b>Managers x 9</b> – 2,640 each per annum On call allowance (Paid to the following managers: CEO, Deputy CEO/Head of Operations, Deputy CEO/Head of OD, Performance Lead, Director of HR, Director of Nursing, Deputy Director of Nursing, Head of Clinical Services/Business Planning, Directorate Nurse Manager)	Business case for continuation of allowance.	Cease
<b>Brothers of Charity Clare</b>	Service Leader LHO +2% 88,496 Salary 84,917-102,812	Business case for alignment with Assistant National Director (Service) scale with a 6.25% reduction and barred at 4 <sup>th</sup> point 84,857-95,919	Cease and further Review / Sizing
	<b>Area Manager</b> – based on a 20% reduction of FAS Grade VI pay scale 65,000	Business case for continuation	Cease and further Review / Sizing
	<b>Principal Social Worker</b> – 1,205 Designated Persons allowance Salary 63,886-73,754	Business case for continuation on personal to holder basis (due to retire in 2032).	Cease
<b>Brothers of Charity - Galway</b>	<b>Director of Services</b> – LHM +6% Salary 87,989-106,585	Business case for alignment with Assistant National Director (Service) scale with a 3% reduction 87,799-106,878	Cease and further Review / Sizing
	<b>Area Manager 51-75 clients</b> Salary 55,472-68,241	Business case to red circle to post holder	Cease and further Review / Sizing
<b>Brothers of Charity - Roscommon</b>	<b>Director of Services</b> - LHM +2% Salary 84,917-102,812	Business case for alignment with Assistant National Director (Service) scale with a 6.25% reduction and barred at 4 <sup>th</sup> point 84,857-95,919	Cease and further Review / Sizing
<b>Brothers of Charity - Limerick</b>	<b>Director of Services</b> – LHM Scale Salary 83,252-100,796	Business case for alignment with Assistant National Director (Service) scale with a 3% reduction bringing salary to 87,799-106,878	Cease and further Review / Sizing
	<b>Head of Integrated Services</b> (Regional Manager – FAS Grade VI scale 65,000-79,756)	Business case for continuation.	Cease and further Review / Sizing

## Decisions on Business Cases reviewed by Internal Review Group

Agency	Compliance issue to be addressed (Details provided by Grade title, allowance and salary paid)	Summary of Business Case made	Internal Review Group decision
Brothers of Charity - South East Region	Director of Services – LHM +6% Salary 87,989-106,585	Business case for alignment with Assistant National Director (Service) scale with a 3% reduction bringing salary to 87,799-106,878	Cease and further Review / Sizing
	Regional Manager – FAS Grade VI scale – 65,000-79,756	Business case to red circle to existing post holder	Cease and further Review / Sizing
	Area Manager 75-100 clients 58,692-72,118	Business case to red circle to existing post holders (DOH approved)	Cease and further Review / Sizing
	Area Manager 50-75 clients x 5 55,473-68,243	Business case to red circle to existing post holders (DOH approved)	Cease and further Review / Sizing
	Services Manager 68,243 + Health & Safety allowance -10,121 + Farm allowance 7,591.	Business case to link salary to Technical Services Officer scale 74,876-88,876. Post holder would not progress beyond 86,152.	Cease and further Review / Sizing
Brothers of Charity - Southern Region	Director of Services – LHO +6% 87,989-106,585	Business case for alignment with AND PCCC scale with a 3% reduction bringing salary to 87,799-106,878	Cease and further Review / Sizing
Cappagh National Orthopaedic Hospital	CEO – flexibility/on call 8,000 Salary 103,943	Business case to continue payment on a personal to holder basis or to assimilate onto nearest comparator DOH scale.	Cease
	Director of Nursing – IR allowance 8,067 Salary 75,766 (DON Band 2)	Business case to continue payment on a personal to holder basis or to assimilate on nearest DOH scale.	Cease
	Financial Controller - Flexibility/On call 8,000 Grade VIII Salary 64,812-74,551	Business case to continue payment on a personal to holder basis or to assimilate on nearest DOH scale.	Cease
	Chairperson to Medical Board allowance 38,653 & Consultant CPD Category 2 Academic Consultant	Business case for continuation of a reduced allowance @ 14,490 on a personal to holder basis or to assimilate onto the recognised salary scale.	Cease



## Decisions on Business Cases reviewed by Internal Review Group

Agency	Compliance issue to be addressed  (Details provided by Grade title, allowance and salary paid)	Summary of Business Case made	Internal Review Group decision
	Secretary of Medical Board - Medical Board 20,675 & EDL & CPD & call outs. Category 2 Consultant	Business case for continuation of allowance of 14,490 on personal to holder basis or to assimilate onto recognised salary scale.	Cease
Central Remedial Clinic	Manager of Client Services – 32,357 CRC funded salary Total salary – 101,469	Permanent contract – retires September 2015	Cease and further Review / Sizing
	ICT Manager – 37,841 – CRC funded salary	On long term sick leave	Cease and further Review / Sizing
	Senior Manager, National Physical Sensory Disability Database – Allowance 13,958 Salary 69,659 (Total 83,617)	3 year contract to April 2015	Cease and further Review / Sizing
	Quality, Risk & Health & Safety Manager – Allowance 13,848 Salary 73,783 (Total 87,631)	3 year contract to April 2015	Cease and further Review / Sizing
	Strategic Development Manager – Allowance 9,821 Salary 91,648 (Total 101,469)	3 year contract to April 2015	Cease and further Review / Sizing
	Medical Director – Medical Director Allowance 19,187 Consultant Type B		Cease and further Review / Sizing
	IT Manager – Allowance 4,725 Salary – 68,564 (Total 73,289)	Permanent contract	Cease and further Review / Sizing
	5 Managers – externally funded pension contribution	IPt pension scheme which has an employer's contribution of 25% and employee contribution of 10% under an approved funding proposal.	Cease and further Review / Sizing
Coombe Women's Hospital	Director of Nursing/Midwifery - Dual allowance 2,166 Salary 75,766 (DON Band 2)	Business case for red circle on a personal to holder basis.	Cease

## Decisions on Business Cases reviewed by Internal Review Group

Agency	Compliance issue to be addressed (Details provided by Grade title, allowance and salary paid)	Summary of Business Case made	Internal Review Group decision
	Director of Nursing/Midwifery – privately funded allowance 6,000	Business case to red circle on a personal to holder basis.	Cease
	Director of Nursing/Midwifery – 20,000 lead role for Quality & Patient safety	Business case to red circle on a personal to holder basis for 3 yrs.	Cease
	<b>Financial Controller</b> - 10,000 allowance Grade VIII Salary 64,812-74,551	Business case to red circle on a personal to holder basis.	Cease
<b>COPE Foundation</b>	<b>Chief Executive</b> – Salary 121,600	Business case for continuation of salary.	Cease and further Review / Sizing
	<b>Head of Client Services/Director of Nursing</b> – Salary 89,120 (Link to point 4 Deputy GM CUH salary scale)	Business case to link to Deputy General Manager (Cork University Hospital & Galway Regional Hospital) @ 89,305	Cease and further Review / Sizing
<b>Daughters of Charity Services for Persons with Intellectual Disability</b>	<b>CEO</b> – Motor car allowance - 11,892 per annum Salary 136,282 (CEO Beaumont scale)	Business case for continuation of motor allowance (contractual obligations)	Cease and further Review / Sizing
<b>Dublin Dental School &amp; Hospital</b>	<b>CEO</b> - TCD lecturing 27,600 Salary 103,200	Business case for recognition of contractual status on personal to holder basis or to assimilate onto nearest DOH scale @ 136,282	One person one salary principle – requires Departmental approval
	<b>Specialist Dentists</b> (x4) External hospital on call	Business case for continuation @ 1,881 per week when clinician is on call.	Cease and further Review/ Sizing
	<b>Facilities Manager</b> - On call 2,893 Grade VIII Salary 64,812-74,551	Business case for continuation on a personal to holder basis.	Cease
	<b>HR Manager</b> – Dual responsibility 3,731 Grade VIII Salary 64,812-74,551	Business case for continuation on a personal to holder basis	Cease



## Decisions on Business Cases reviewed by Internal Review Group

Agency	Compliance issue to be addressed  (Details provided by Grade title, allowance and salary paid)	Summary of Business Case made	Internal Review Group decision
	Dean 1,519 allowance for senior admin tasks Professor/Consultant	Business case for continuation on a personal to holder basis.	Cease
Leopardstown Park Hospital	Medical Officer - 86,560 pro rata (37,097 for 15 hr week) 9,637 on call allowance	Medical Officer Business case received to re designate position to Medical Officer Principal salary of 92,258 with an appropriate on call allowance.	Cease and further Review / Sizing
Mater Hospital	Consultant Administrative Sessions x 9 posts :		
	Chairman of Medical Executive -28,035	Business case for retention	Cease
	Deputy Chairman, Medical Executive – 14,017	Business case for retention	Cease
	Honorary Secretary, Medical Executive – 27,007	Business case for retention	Cease
	Dean of Post Graduate Education – 14,017	Business case for retention	Cease
	Clinical Audit Lead – 18,035	Business case for retention	Cease
	Chair of Research Ethics Committee – 14,017	Business case for retention	Cease
	Director, National Centre for Cardiothoracic Surgery – 14,017	Business case for retention	Cease
	Clinical Lead, Unscheduled Care – 14,878	Business case for retention	Cease
	Clinical Director – St. Paul's Hospital – 14,878	Business case for retention	Cease
	Emergency & Speciality Medicine – 29,756	Business case for retention	Cease
Muiriosa Foundation, Sisters of Charity of Jesus and Mary	Director of Finance - 6,215 Additional responsibility allowance & 15,000 once off special payment Grade VIII Salary 64,812-74,551	Business case for continuation of 6,215 allowance	Cease
	2 Senior Managers – Funded defined benefit pension scheme	Business case for continuation	Ongoing engagement

## Decisions on Business Cases reviewed by Internal Review Group

Agency	Compliance issue to be addressed (Details provided by Grade title, allowance and salary paid)	Summary of Business Case made	Internal Review Group decision
			with the Pensions Policy Unit, DoH to resolve issue
National Maternity Hospital, Holles Street	Secretary/Manager – 39,000 externally funded Salary 103,943	Business case for continuation on a personal to holder basis.	Cease
	Financial Controller – 30,000 externally funded Grade VIII Salary 64,812-74,551	Business case for continuation on a personal to holder basis.	Cease
	Director of Midwifery & Nursing – 37,500 externally funded Salary 65,149- 75,766 (DON Band 2)	Business case for continuation.	Cease
National Rehabilitation Hospital	CEO –Foundation/Company Secretary allowance 25,000 Salary 103,943	Business case for realignment of salary with CEO DATHs scale (136,282) on a personal to post holder basis.	Cease and further Review / Sizing
	Chair of Medical Board – 41,213 Consultant	Business case for continuation until the appointment of a Clinical Director (end of 2014)	Cease
	Secretary of Medical Board – 27,476 Consultant	Business case for continuation until the appointment of a Clinical Director (end of 2014)	Cease
Our Lady's Hospice, Harolds Cross	CEO - Blackrock Hospice Allowance 12,700 Salary -100,796 paid to current CEO (on secondment from HSE) (Business cases states that salary is CEO/Sec Manager Vol Hospitals Group 1 scale 81,672-98,867)	Business case for continuation for duration of CEO contract.	Cease
	CEO – Fundraising allowance 7,000	Business case for continuation for duration of CEO contract	Cease
	Head of HROD - IR allowance 8,769 Grade VIII Salary 64,812-74,551	Business case for continuation for duration of contract	Cease
	Head of HROD – Mission Effectiveness allowance 10,000	Business case for continuation for duration of contract	Cease



## Decisions on Business Cases reviewed by Internal Review Group

Agency	Compliance issue to be addressed  (Details provided by Grade title, allowance and salary paid)	Summary of Business Case made	Internal Review Group decision
	Head of Finance -Company Secretary allowance 4,000 Grade VIII Salary 64,812-74,551	Business case for continuation for duration of contract.	Cease
	Head of Finance -Fundraising allowance 6,000	Business case for continuation for duration of contract.	Cease
	Director of Nursing – Quality, Risk & Corporate Governance allowance 6,000 Salary 75,766 (DON Band 2)	Business case for continuation for duration of contract.	Cease
	Director of Nursing – Head of Clinical Services allowance 10,000	Business case for continuation for duration of contract.	Cease
	Medical Director (Palliative Care) – 37,506 allowance	Business case for continuation in the absence of a Clinical Director	Cease
Our Lady's Children's Hospital, Crumlin	CEO – allowance 30,000 Salary 103,943	Business case received to bring the CEO base salary in line with DATHS CEO scale (136,282)	Cease
	Director of Pathology – additional duties allowance 16,648 Consultant	Business case for continuation of allowance	Cease
	Clinical Risk Advisor – 27,931 Consultant	Business case for continuation of allowance.	Cease
	Chair of Medical Board – 36,417 Consultant	Business case for continuation of allowance	Cease
	Secretary to Medical Board – 16,648 Consultant	Business case for continuation of allowance	Cease
Pea mount	CEO – On campus accommodation Salary -136,282	Business case for continuation.	Cease and further Review/ Sizing
	Deputy General Manager x 2 – Director of Finance - Deputy GM scale 95,972 Director of Nursing - Deputy GM scale – 95,972	Background information provided	Cease and further Review/ Sizing

## Decisions on Business Cases reviewed by Internal Review Group

Agency	Compliance issue to be addressed (Details provided by Grade title, allowance and salary paid)	Summary of Business Case made	Internal Review Group decision
Rotunda	<b>Master</b> - non publicly funded 20,000	Business case for continuation at an amount of not more than 25,000 per annum	Cease
	<b>Secretary/GM</b> -non publicly funded 17,000 Salary 92,821	Business case for continuation at an amount not more than 20,000 per annum	Cease
	Secretary/GM -Dual allowance 4,025	Business case for continuation.	Cease
	Secretary/GM - 294 phone allowance	Business case to red circle to post holder.	Cease
	<b>Director of Midwifery</b> - 16,000 non publicly funded 81,552 (DON Band 1)	Business case for continuation at an amount not more than 15,000 per annum	Cease
	<b>Financial Controller</b> - non publicly funded 19,000 Grade VIII Salary 64,812-74,551	Business case for continuation at an amount not more than 17,000 per annum	Cease
	<b>HR Manager</b> - 6,000 non publicly funded Grade VIII Salary 64,812-74,551	Business case for continuation.	Cease
	<b>Facilities Manager</b> – dual allowance 3,732 Grade VIII Salary 64,812-74,551	Business case for continuation.	Cease
	<b>Clinical Lead Laboratory Medicine</b> (Director of Pathology) - 13,527 allowance Consultant	Business case for continuation to increase to 15,000	Cease
	<b>Clinical Lead Anaesthetics</b> (Medical Director anaesthesia) - 14,454 allowance Consultant	Business case for continuation to increase to 15,000	Cease
	<b>Clinical Lead Neonatology</b> -16,000 (paid in 2012, nil paid in 2013) Consultant	Business case for continuation of 15,000	Cease
<b>Royal Hospital Donnybrook</b>	<b>CEO</b> - Health Insurance 1,792 Salary 103,943 (Group 1 98,867 + 5,076 PRA Adjustment )	Business case to red circle on personal to holder basis.	Cease



## Decisions on Business Cases reviewed by Internal Review Group

Agency	Compliance issue to be addressed (Details provided by Grade title, allowance and salary paid)	Summary of Business Case made	Internal Review Group decision
	DOH state salary should be at Group 2 (64,812-74,551)	Business case re banding of hospital. Business case to red circle CEO as Group 1.	Cease and further Review / Sizing
	CEO - 1,485 on call allowance	Business case submitted – Non Clinical on call allowance	Cease
	<b>Medical Director</b> - 1,485 on call allowance	Business case submitted – Non Clinical on call allowance	Cease
	<b>Director of Nursing</b> - 2,982 allowance Salary 63,652-67,982 (Band 3)	Business case for re banding from Band 3 to 2a	Cease and further Review / Sizing
	Director of Nursing - 1,485 on call allowance	Business case submitted – Non Clinical on call allowance	Cease
	Director of Nursing 1,030 re difference in pension payments from Band 3 to Band 2a	Business case for continuation	Cease
	<b>Operations Manager</b> (Allied Health Services Manager)- 79,481 Service Manager Salary	Currently on secondment to HSE. Business case for grading of post to reflect post holder's current salary 65,376-79,481	Cease and further Review / Sizing
<b>Royal Victoria Eye &amp; Ear Hospital</b>	<b>Director of Education &amp; Research</b> - 35,943 allowance Consultant	Business case for 2 Consultant sessions per month for 3 year term	Cease
	<b>Medical Director</b> - 27,054 Allowance Consultant	Business case for 2 Consultant sessions per month for 3 year term	Cease
<b>South Infirmary Victoria University Hospital, Cork</b>	<b>CEO</b> - 11,485 company secretary allowance Salary 103,943	Business case for continuation (paid to current CEO since 2000).	Cease
<b>Stewarts Hospital</b>	<b>Asst. Director of Nursing</b> x 5 – 14.9% salary -9,694 Salary ADON Mental Health 56,138-65,066 <b>Technical Services Officer</b> – on call 14.9% salary] 74,876-88,764	Business case for continuation as part of contract of employment  Business case for continuation as part of contract of employment since 1991	Cease  Cease

## Decisions on Business Cases reviewed by Internal Review Group

Agency	Compliance issue to be addressed (Details provided by Grade title, allowance and salary paid)	Summary of Business Case made	Internal Review Group decision
St. James' Hospital	<b>Principal Social Worker</b> – 2,947 allowance Salary 63,886-73,754	Business case for continuation (in place since 2000)	Cease
	<b>CEO</b> - travel allowance 8,937 Salary 136,282	Business case received for contractual duration until end of 2016	Cease
	<b>CEO</b> - Lecturing - TCD	Letter confirming that this salary is paid directly from TCD payroll	One person one salary principle – requires Departmental approval
	<b>Director of HR</b> - 3,613 & 3,613 Dual responsibility allowances Salary 108,332 (AND grade)	Business case for continuance until review date of 1/11/2014	Cease
	<b>Fire Services Manager</b> - On call allowance - 7,724 Grade VII Salary 64,417	Business case for continuance – 7,724	Cease
	Clinical Director (x10) 28,979 Clinical Directors Allowance	Business case for allowance for 6 Clinical Directors @ 45,998 each per annum (to reflect revised Clinical Directorate structure)	Cease
	<b>Director of Post Graduate Medical Education</b> - 51,617 post graduate coordinator allowance (Consultant Rheumatologist)	Business case for continuation until next contract review in 2015	Cease
	<b>Director Clinical Audit Programme</b> - 36,417 allowance (Consultant in Emergency Medicine)	Business case for continuation of allowance.	Cease
	<b>National Haemophilia Director</b> - 43,468 allowance (Consultant Haematologist) -	Business case for linkage of allowance in perpetuity to the post (45,998)	Cease
	<b>Chairperson of Medical Board</b> 24,328 allowance (Consultant Psychiatrist)	Business case for continuation of allowance.	Cease
<b>St. John of God Hospitaller Services</b>	<b>Administration Manager Kildare</b> –15,040 allowance Grade VII Salary 61,417	Business case for approval to pay Grade VIII salary which is the salary applicable to all Administration Managers in SJOG Community Services	Cease
<b>St. Michael's House</b>	<b>CEO</b> – 141,638 (129,334 + 12,304 privately funded)	Business case to align to salary of 136,282	Cease and further Review /



## Decisions on Business Cases reviewed by Internal Review Group

Agency	Compliance issue to be addressed (Details provided by Grade title, allowance and salary paid)	Summary of Business Case made	Internal Review Group decision
	<b>Director of Operations</b> – 121,926 (100,796 + 21,796 privately funded)	Business case to align salary with approved scale as close as possible to 121,926	Sizing Cease and further Review / Sizing
	Salary paid as former Programme Manager grade non EHB scale		
	<b>Regional Director x 2</b> - 111,874 (91,577 + 20,297 privately funded)	Business case to align salary with approved scale as close as possible to 111,874	Cease and further Review / Sizing
	<b>Regional Director x 1</b> – 98,757 + 7,180 privately funded) Salary paid as Functional Officer grade		
	<b>Communications &amp; Regional Services Support Manager</b> 97,812 (91,577 + 6,235 privately funded) Functional Officer scale	Business case to red circle on personal to holder basis	Cease and further Review / Sizing
<b>St Vincent's Healthcare Group</b>	<b>Chair of Medical Board &amp; Medical Executive</b> – 19,777	Business case for continuation	Cease
	<b>Chair of Surgery Sub Group</b> – 11,212	Business case for continuation	Cease
	<b>Hon Sec of Medical Board</b> -16,648	Business case for continuation	Cease
	<b>Chair of Pathology</b> 15,040	Business case for continuation	Cease
	<b>Chair of Radiology</b> - 15,040	Business case for continuation	Cease
	<b>Chair of Physicians</b> – 16,648	Business case for continuation	Cease
	<b>Chair of Anaesthesia</b> – 15,040	Business case for continuation	Cease
	<b>Intern Tutor</b> – 13,527	Business case for continuation	Cease
	<b>Director of Education &amp; Research Centre (ERC)</b> – 30,080	Business case for continuation	Cease
	<b>Palliative Care</b> – 21,505	Business case for continuation	Cease
<b>Temple Street Children's University Hospital</b>	<b>Director of Finance</b> – 13,143 allowance Salary 79,481 (Functional Officer scale)	Business case for continuation to post holder	Cease
	<b>Director of Nursing</b> – 3,432 dual duty allowance	Business case for continuation to post holder.	Cease

## Decisions on Business Cases reviewed by Internal Review Group

Agency	Compliance issue to be addressed (Details provided by Grade title, allowance and salary paid)	Summary of Business Case made	Internal Review Group decision
	Salary 75,766 (DON Band 2)		
	<b>Chair Medical Board</b> - 29,756 Consultant	Business case for continuation of payment to post holder	Cease
	<b>ENT Consultant</b> - 13,472 allowance for Money Follows the Patient & Casemix initiatives	Business for continuation on personal to holder basis.	Cease
	<b>Director of Renal Unit</b> - 14,, 878 allowance Consultant Type B	Business case for continuation	Cease
	<b>Director of the Child Mental Health Unit</b> - 14,878 allowance Consultant	Business case for continuation of payment to post holder	Cease
	<b>Director of Metabolic Unit</b> - 13,422 Consultant Type B	Business case for continuation	Cease
	<b>Occupational Health Physician</b> - 2,402 allowance	Business case for continuation of payment to post holder.	Cease
	<b>Deputy Laboratory Manager</b> – dual duty allowance 3,731 Chief Medical Scientist grade 58,683-73,309	Business case for continued payment to post holder.	Cease



