Submission to the Special Group on Public Sector Numbers and Expenditure Programmes by the Health Vote Units, Sectoral Policy Division

1. Introduction

1.1 The role of Sectoral Policy Division is, among other things, to develop policy and to coordinate the implementation of those policies in conjunction with Departments and agencies. The Health Vote Group, SPD submission to the Special Group on Public Sector Numbers and Expenditure Programmes has been drafted with a view to identifying areas that can yield savings in the short term or through longer term reform of the health sector. As requested by the Special Group it has been prepared without consultation with the Department of Health and Children or the HSE and has been prepared on the basis of existing information available to the Department of Finance from the Department of Health and Children and the HSE, mainly briefing notes, service plans, performance management reports, annual reports, management consultancy reports (only some of which are available to the Department) and other source material such as C&AG Reports etc.

1.2 Health expenditure has been the most difficult Vote to deal with for a long time past. The structure of the system, the demand led nature of much of the service, the high political profile, the strength of vested interests, the vulnerability of the client group and the importance of local issues have militated against clear, rational, efficiency measures and cost containment overall. Whilst there have been significant increases in costs and expenditure in the health sector, there has also been a substantial increase in the level and range of services, particularly in acute services and care in the community through an expansion in home care.

1.3 In the case of the Department of Health and Children and the Office of the Minister for Children and Youth Affairs, it is structured around subheads in their votes, with each subhead generally corresponding to a programme. As the HSE has so far failed to account for its voted expenditure in line with the new Vote structure required in the 2008 Revised Estimate Volume (REV) and as its current Vote structure does not provide a meaningful basis for accounting for its financial and management performance, the material in this submission for the HSE is structured around the care group programmes in the HSE's

service plan and performance management reports. Due the manner in which the HSE accounts for Voted Gross expenditure on a net basis (own income from hospitals etc is retained by them) and the inconsistent presentation of information between its service plan, management performance reports and capital plan there may be differences between certain expenditure provisions and gaps in information as set out in this programme presentation. However, data on financial and performance indicators has been provided where it has been possible to identify the data from the various sources available. In some instances, data has had to be substituted from the REV to provide some basic information.

1.4 Some of the savings identified on pay may be overtaken by the general policy on pay announced by the Government.

1.5 Where it is considered that savings can be achieved options are given and they are rated according to risk – high, medium and low, reflecting the degree of difficulty associated with their deliverability. Options classified as high risk are generally those where there is likely to be concerted opposition to their implementation because they involve abolition of or fundamental change in entitlements and additional complications such as IR, legislative change etc. Estimates of savings from these options are based on the information available. Each option under each programme heading does not generally take account of the implications of the other options under the same heading. The total savings shown in the summary table under each category of risk is the sum of lowest option in each category and the sum of highest option in each category.

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Summary of Recommended Savings

Programme	Options for Savings	Savings €m			Savings Time Frame
		High Risk	Medium Risk	Low Risk	
Administrative savings for Department of Health and Children	[TEXT WITHHELD – SECTION 21]	S.21			S.21
	Reduce the Department by 1/3			15	2010
	Rationalisation of 17 Agencies			15	2010
Administrative savings for the HSE	[TEXT WITHHELD – SECTION 21]		S.21		S.21
	Eliminate all bonus payments	S.21			S.21
	[TEXT WITHHELD – SECTION 21]				
	5% cut in corporate expenditure		40		2010
Grants to Health Bodies	[TEXT WITHHELD – SECTION 21]	S.21			S.21
	Remove Exchequer element of Agencies part funded by National Lottery		1.8		2010
	Reduce Exchequer element of grant for same agencies by 20%		0.4		2010
	Merge Ombudsman for Children with others		0.2		2010
	[TEXT WITHHELD – SECTION 20 (1)]	S.20 (1)			S.20 (1)

	Restrict NTPF to private facilities home and abroad		7.5		2010
HEP C Tribunal and Other Inquiries	[TEXT WITHHELD – SECTION 21]	S.21			S.21
Early Childcare Supplement	Abolish the ECS.# Reduce the ECS to the children aged 4½.# Reduce the level of the ECS by 20% to €900 per year.# Introduce a means test to save up to 20%	397 88 80 80			2010 2010 2010 2010
National Childcare Investment	Abolish the transitional provisions Alter the means test by eliminating Band C Rationalise the administrative structures	2 5 3			2010 2010 2010
Children & Families		-	-	-	
Primary Care	[TEXT WITHHELD – SECTION 21] Invite tenders by open competition to provide services under the GMS Revise the income guidelines to the basic rate of social welfare (jobseekers allowance), so that all existing non-medical allowances and HSE discretion are removed and replaced, instead, with a variable allowance based on medical needs Estimated saving of [TEXT WITHHELD – SECTION 20 (1)] €70.5m, [TEXT WITHHELD – SECTION 20 (1)]	S.21 370 70.5 [S.20 (1)]			S.21 2010 2010

	Severely restrict HSE discretionary cards and reduce the number of allowances or cap them. Introduce a charge for card holders for all items dispensed.	150 100			2010 2010
Acute Hospitals, including Cancer Care	Rationalise hospitals and close or down grade inefficient ones Gross €500m. Reinvest in developing primary community services Introduce mandatory protocols which require hospitals and clinicians to prescribe generic medicines, off patent drugs and value for money high tech treatments Progressively move towards the full economic cost of charging for private facilities in public hospitals and Increase A&E Charges and public hospital inpatient charges	80		74	2010 - 2115 2010 2010
Disability and Mental Health		-	-	-	
Care of Older People	[TEXT WITHHELD – SECTION 20] Increase the percentage of care costs under the Fair Deal contributed by an individual from their residence Charge the full economic cost	S.20 75 120			S.20 2010 2010

	of Homecare packages Charge the full economic cost of Homehelp For Homecare packages introduce a means test	180 24			2010 2010
Capital	[TEXT WITHHELD – SECTION 20]		S.20		S.20
Total range within risk		**S.20 & S.21 (1) (c)**	**S.20 & S.21 (1) (c)**	**S.20 & S.21 (1) (c)**	

[TEXT WITHHELD – SECTION 21]

Depends on decisions to be taken by the Government in the February 2009 savings in public expenditure.

2. Overall trends in expenditure on Health Vote Group

2.1 Health Expenditure has almost doubled in the last 8 years.

Trends in Health Group expenditure from 2002 to 2009

Year	Vote 39 (Vote 33 pre 2005) Current €m	Vote 39 Capital €m	Vote 39 Total €m	Vote 40 - HSE Current €m	Vote 40 Capital €m	Vote 40 Total €m	Vote 41 - OMC Current €m	Vote 41 Capital €m	Vote 41 Total €m	Health Group Current €m	Health Group Capital €m	Health Group Total €m	Y-o-Y Increase €m	Y-o-Y %
2002	7,846	507	8,353							7,846	507	8,353	1,276	18.0%
2003	8,789	514	9,303							8,789	514	9,303	950	11.4%
2004	272	12	284	9,768	497	10,265				10,041	508	10,549	1,246	13.4%
2005	325	10	335	10,972	514	11,486				11,297	524	11,821	1,272	12.1%
2006	347	17	364	11,851	444	12,294	319	35	354	12,517	496	13,012	1,192	10.1%
2007	400	33	433	13,388	558	13,946	493	108	601	14,281	699	14,980	1,968	15.1%
2008	479	19	497	14,353	575	14,928	568	80	648	15,399	674	16,073	1,093	7.3%
2009	515	15	531	14,791	465	15,256	488	60	548	15,794	540	16,335	262	1.6%

2004 HSE Current includes €480m in respect of hospital and other charges, relating to the former Health Boards, previously collected and retained by the Boards.

Source 2002-2007 Appropriation Accounts, 2008 Provisional Outturn, 2009 Budget

2.2 Health accounts for some 28% of total current expenditure and 6.6% of capital expenditure. Of the total 2009 current expenditure provision of €15.8b for the Health Group of Votes, some €8.2b or 52% is accounted forby pay and pensions.

2.3 The following table sets out an overview of expenditure broken down between the Department of Health and Children and Office of the Minister for Children and Youth Affairs and the HSE by programme. (See introduction)

Programmes	**2008 Estimates € million**	**2009 Estimate € million**
Vote 39 – Office of the Minister for Health & Children& Vote 41 – Office of the Minister for Children & Youth Affairs		
1.Administrative Budget	44	43
2. Grants to Health Bodies	309	302
3. Hep C Tribunal & other inquiry costs	149	166
4. Early Childcare Supplement	*506*	*397*
*5. National Childcare Investment Programme**	*44*	*74*
6. Miscellaneous (both Votes)	20	21
Total	**1072**	**1003**

Vote 40 – HSE		
1. Policy & Corporate Support	730	805
2, Children and Families	557	581
3. Primary Care	3071	3078
4. Acute Hospitals (incl Cancer Care)	4660	4657
5. Cancer Control	22	37
6 Disability & Mental Health	2480	2530
7. Care of Older People	1412	1474
Total Gross Programme Expenditure	**12,932**	**13,162**
Total Rev allocation	**14,338**	**14,791**
Difference	**1,406**	**1,629**

Source: 2009 Budget and 2009 HSE National Service Plan. Difference relates to the netting-off by the HSE of certain receipts of hospitals and other bodies funded

Capital Programme	**2008 Estimates € million**	**2009 Estimate € million**
HSE	594	465
Health and Children	20	15
Office Minister for Children & Youth	102	60

3. Context and role of the Department of Heath and Children and the HSE

3.1 The HSE was established in 2005 (replacing the former health boards and Eastern Regional Health Authority) as a national agency with responsibility for the delivery of health and personal social services. Almost 4 years later, despite its transformation programme, its many service reviews and attempts to date at service reconfiguration and operational improvements, the numbers employed in the health sector continue to grow. At end 2008, there are some 111,575 whole time equivalents employed in the health sector.

3.2 Acute hospital services are delivered through 50 hospitals (statutory and voluntary) while PCCC services are currently delivered through 32 local area health offices. The HSE grant aids (current and capital) close to 4,000 voluntary agencies involved in the provision of health and personal social services. Administratively it is organised into 8 regions based on the former health board regions.

3.3 The HSE is currently undertaking another restructuring which it intends to have in place and fully operational in 2010. It is restructuring its top level management so there will be 9 national directors instead of 11 at present, a single national director for service delivery (Hospital and PCCC), a separate director for planning, a new national director for communications and a clinical director. It plans to roll out integrated services, involving integration of the hospital and PCCC pillars through 6-8 operational units, including a mixture of hospital, primary care and community services. This will be delivered at regional level through regional operations directors who will have full authority and accountability for the delivery of all health and social care services in the region to an agreed service plan and budget within an overarching national policy and operating framework.

3.4 Since the HSE was established functional responsibility for hospital planning including casemix, Administration of Voluntary Hospital and Health Agency Superannuation Schemes, Health Promotion, Administration of Health Service, Personnel Census, initial drafting of material for responses to PQs, FOI Requests and Representations has transferred to it from the Department of Health and Children. The function of the Department of Health and Children is to develop health policy and to hold the HSE account. It does this through engagement with the HSE in relation to feedback on policy issues based on its operational experience and through approval of the HSE's annual service plan and capital plan. It also monitors the HSE's performance through ongoing contacts at official level and various committees/working groups.

4. Administrative savings Department of Health and Children

4.1 The Department of Health and Children currently has 1 Minister and 4 Ministers of State compared to 3 Minister of State in 2004. Each of the Ministers of the State now heads up a dedicated office or has been assigned a particular policy responsibility: Office of the Minister for Children & Youth Affairs, Office of Minister for Older People, Office of Minister for Equality, Disability & Mental Health and Minister of State with responsibility for Health Promotion and Food Safety. All of these offices are staffed and funded from the Department of Health and Children's resources. In addition to the HSE and the voluntary agencies which it funds and the Department of Health and Children, there are currently 25 agencies that between them have Exchequer funded budgets of around €300m and employ some 850 staff. As part ofthe Government's current programme of efficiency savings and agency rationalisation, it is planned to rationalise 17

of these agencies. The synergies and efficiencies resulting from the proposed rationalisation of agencies [TEXT WITHHELD – SECTION 20 & SECTION 21]

4.2 The volume of legislation and policy/strategy documents produced are crude indicators of policy output, (although it can be argued that publications represent only a fraction of policy output). Between 2005 and 2008, 30 strategies/ policy/ services reviews or VFM reports or an average of 7.5 per year have been produced by the HSE, while the Department of Health and Children has produced 20 or an average of 5 per year. The Department has not published any major policy document since 2007. 77% of the HSE's strategy/service review reports were produced jointly or by external management consultants while 70% of the Department's was produced jointly or by external consultants. As regards legislation the other main policy output of the Department, it has produced 18 Bills/Acts an average of 4.5 per year and some 197 Statutory Instruments or 49 per year. (Appendix 2 refers). Broadly speaking, the legislation has been produced to provide a statutory basis for the HSE and new bodies as part of the process of structural reform of the health sector (18%), to address emergencies which have arisen as a result of deficiencies in existing health legislation (9%) and 22% to give effect to strategic policies developed by the HSE and the Department with the balance being made up of routine secondary legislation much of it technical and or European Union related.

5. Administrative Budget

Administrative Budget Department of Health & Children	
2008 Provisional Outturn €m	**2009 Estimates Allocation €m**
46	43

Source: 2009 Budget and Department of Health returns

5.1 The authorised staffing complement for the Department of Health and Children (including OMC&YA) is 594.5 wholetime equivalents (WTEs) The Number serving is 539, comprising 1 Secretary General, 1 Deputy Secretary General (OMC&YA), 7 Assistant Secretaries, 2 Directors, 52 POs,109 APs, with the balance made up of administrative and technical staff.

5.2 The following table sets out trends in employment numbers in the Department:

2002	2003	2004	2005	2006	2007	2008
645	649	626	604	613	604	539

5.3 The reduction in numbers of 106 between 2002 and 2008 is accounted for by the transfer of GRO to Social & Family Affairs (-61); establishment of HSE (-37); establishment of OMC (+20); others -28.

Options for savings

5.4 The development of the functions of the Department of Health and Children (including the OMC&YA) and the HSE and the volume of legislation and policy/strategy documents produced by it, when viewed in the light of the resources available to it, would indicate that the Department of Health should be significantly reduced in size.

1. [TEXT WITHHELD – SECTION 21]
2. Reduce the Department by one third. This would produce a staff saving of 180 and an estimated saving of € 15m approximately.
3. Rationalisation of 17 Agencies €15m

Risks

5.5 [TEXT WITHHELD – SECTION 21] The risk involved in Options 2 and 3 would be low, although the agency rationalisation may take time to address legislative, IR and other considerations.

6. Overview of HSE financial management

6.1 Account must be taken of the HSE's financial management performance in looking at the scope for making and delivering savings in the health sector. Since its establishment, and despite unprecedented levels of resources being made available in its first three years, the HSE has struggled to live within its allocated budget. It only managed to do so up to 2006 by diverting development moneys for new service developments, capital moneys and long-term care repayment moneys allocated in the annual estimates and budget away from their intended purpose. In 2007 and 2008 it required supplementary estimates totalling €245m and €420m respectively.

6.2 The 2008 HSE Service Plan, as approved and published, set out to deliver value for money savings of 2% or €280m in 2008. (This included drug cost savings in respect of reduced wholesale margins for pharmacists of €120m, overtime and agency €55m, travel & subsistence €10m, telephony €2.5m, procurement and contracts management €12m with the balance to come from PCCC €64m (not specified) and NHO €36m (not specified)). By March 2008, the HSE reported that expenditure on community schemes such as Medical Cards, Drug Payment Scheme, Long Term Illness Scheme and Domiciliary Care Allowance were ahead of budget. It also indicated that demand for hospital services was ahead of target and that it was anticipating an end-year overrun in the order of €300m could arise unless significant corrective actions were taken.

6.3 In mid year, it adopted a new four phase breakeven plan providing for reductions of €249m to end June under phases 1 and 2 (which included reduced targets for the National Hospitals Office (NHO) of €63m and €31m for Primary Community and Continuing Care (PCCC) respectively and further savings of €14m in respect of temporary staff, education & training, consultancy, taxis and management consultants and Office Accommodation) to address emerging spending pressures. The plan also provided for the adoption, if necessary, of non-frontline spending savings of some €104m (across a range of measures including education & training, IT and IT capital, legal, grants to agencies, maintenance, income measures from car parks and private insurance, population health/pandemic drugs, laboratory, catering, temporary contracts etc.). It further provided for nearly €6m savings from intensification of PCCC measures under phase 3 with the possibility of service level reductions under its service plan of some €37m from PCCC and over €21m from NHO under phase 4 to end December. There were difficulties reporting financial performance in the HSE for a significant part of 2008 due to the impact of the IMPACT Union dispute over health cutbacks. However, at end October, 2008 the HSE was reporting projected savings of some €205m under phases 1 and 2 and additional projected savings of €145m under phase 3 and up to €58m under phase 4 of its breakeven plan. The 2009 HSE Service Plan indicates that €280m VFM savings were actually achieved in 2008 but no specifics are given as to where those savings were achieved and how the various VFM measures provided for in its 2008 breakeven plan contributed.

6. 4 In the event, the HSE managed to breakeven on its core current expenditure services in 2008 by viring €20m from ICT capital to currentspending but two supplementary estimates were required to meet unforeseen:

- shortfall in UK migrant receipts of €350m,
- additional demand under for the Long term Care Repayment Scheme costing €89m,
- the restoration from 1 October 2008 of the wholesale margin for pharmacists €32m on foot of the High Court Judgement in the Hickey Pharmacy case, and
- the cost of the hospital consultant's deal €72m concluded in 2008

6.5 Only €4m of the provision of €72m for consultants deal was actually paid out in 2008 because the consultants did not show sufficient progress in meeting their new contractual performance requirements. If this deal were to be implemented in 2009 with full retrospection an additional €67m would have to be found to fund it.

6.6 The gross supplementary estimates of €543m required were partially offset by some €123m of Development Funding (diverted from the €230m provided for in the 2008 Budget) as part of the €144m efficiency savings agreed by Government in July of 2008.

6.7 Reflecting overall budgetary constraints, the increase in the 2009 current allocation for HSE of €454m or 3.2% is considerably less than the increase provided for in its 2008 REV allocation of some €900m or 6.9%. Underpinningthis 2009 HSE allocation, is savings of some €390m (administrative €115m savings: payroll, legal, advertising, T&S, procurement, nurses training, certain drug costs; some €175m, including the €100m on the over 70's Medical Cards, €20m Cash Cap on Medical Card Discretion and an increase in Drug Payment Scheme threshold to €100 p.m.) andother operational efficiencies of €100m (from increases in long stay charges, privatebeds in public hospitals and A&E charges). (In addition to the current savings of €390m from the HSE Vote, Budget 2009 also provided for savings of nearly €110m on the Early Childcare Payment in the OMC Vote to sustain the 2009 levels of service envisaged for HSE).

6.8 The approved 2009 HSE Service Plan identifies savings of €395m (€115m VFM efficiency savings (to include 3% reduction in payroll costs, mental health overtime, travel &subsistence, legal, advertising, training &education, drugs formulary, maintenance, patient transport, blood usage and reconfiguration of administrative

processes and childcare) and €280m VFM savings carried through from 2008 savings. It is not clear to what extent there is overlap between the projected €115m efficiency savings and the €280m VFM savings. The latter are to be specified in 2009 business plans but include areas listed such as procurement efficiencies, management of blood products, facilities management as well as additional areas such as dental treatment services and non-emergency patient transport.

6.9 The 2009 plan also identified the following risks to the HSE ability to deliver the service levels:

- €100m additional savings which (like all other public bodies) it is required to achieve to fund the 2009 cost of the new national pay agreement
- €100m savings from the Over 70s Medical Cards;
- the savings (unspecified) in respect of the wholesale margins for pharmacies;
- growth in demand led schemes (unspecified)
- the possibility of additional costs (unspecified). as a result of people not renewing their private health cover and switching to public health care.

6.10 In addition to the above, the HSE could have to payback the savings from the reduction in the wholesale margins for pharmacists from March 2008 to October 2008 when it lost the court case as well as face legal costs. The Department of Health and Children has only recently signalled its intention to undertake the required consultations with pharmacy interests (consistent with the Hickey High Court Judgement) to enable the Minister for Health and Children to determine the appropriate margin to be recouped on community drugs.

6.11 In summary, therefore, care must be taken to try and avoid double counting in any savings which may be identified and to achieve deliverability of savings options. In so far as this is possible from the limited information available, the options for savings put forward in this paper seek to reflect this risk

7. Health Sector Numbers

7.1 Since the establishment of the HSE in 2005 to end 2008, there has been an estimated increase of some 12,100 or 12.2% in the numbers employed in the health sector. HSE employment increased by 10.6% as compared to the voluntary health sector growth of 15.5%. The growth in employment in the statutory and voluntary sectors partly reflects an

increase in the range and level of service outputs and, in the case of the HSE; it also includes the absorption of specialist agencies.

7.2 At the end of September 2008, there were 129,385 staff or 110,819 whole time equivalents employed in the health sector, 65.6% in the HSE and 34.4% in the voluntary sector. It is expected that at end year when most of the development posts provided for in Budget 2008 will have been filled the number of whole time equivalents employed will be around 111,500.

WTEs	**2004**	**2005**	**2006**	**2007**	**2008**	**Increase Over 2004**
	Qtr 4	**Qtr 4**	**Qtr 4**	**Qtr 4**	**Qtr 3**	
Health Service Executive	65,776	67,704	70,324	73,461	72,753	6,977 (10.6%)
[1]NHO Voluntary Hospitals	20,022	20,963	21,879	23,154	22,833	2,811 (14.0%)
Voluntary Disability ([2]PCCC)	10,494	10,842	11,471	12,221	12,529	2,046 (19.4%)
Other PCCC Voluntary Agencies	2,431	2,468	2,598	2,669	2,704	273 (11.2%)
Total	**98,723**	**101,978**	**106,273**	**111,505**	**110,819**	**12,096 (12.2%)**

1= National Hospitals Office. 2 = Primary, Community and Continuing Care.
Source: HSE Census. Rounding may affect totals

7.3 In line with the strategic direction of health policy the larger growth in employment has occurred in Other Patient and Client Care, 3,700 or 25%, Health and Social Care Professionals, 2,918 or 23%, Medical/ Dental, 1090 or 15%, and Nursing 3,585 or 10%, while Management/Administrative Staff grew by 1,771 or11% and General Support Staff fell by 971 or 7%.

7.4 Attempts have been made through the years to contain the growth in employment numbers in the health sector. A newly revamped employment control framework was introduced in 2008 under the Department of Finance sanction for HSE current expenditure in another attempt to control the growth in health sector numbers. It set a monthly employment

ceiling for the health sector of 110,600 whole time equivalents (some 700 less than the numbers in the 2008 HSE Service Plan as approved by the Department of Health and Children) which was not to be exceeded, save for the filling of 1050 development posts in certain priority services elderly, disability, cancer etc, on foot of the provision of €125m (excluding the Fair Deal) development moneys in Budget 2008. The approved end 2008 employment level was therefore set at 111,650. The 2008 approved employment control framework also set a two year reconfiguration target for the redeployment of some 1,800 staff from the hospital sector to PCCC and 260 staff from HSE corporate and population health into PCCC.

7.5 It has been successful in keeping the numbers employed on a monthly basis below the approved ceiling. It is anticipated that **at end 2008 there be will be around 111,500 employed in the health sector** (includes 855 development posts and transfers of HRB:16, RCSI: 9, PGMDB: 13) some 180 or so below the approved ceiling accounted for mainly by a shortfall in the filling of development posts provided for in Budget 2008.

7.6 **However, the employment control framework has not been effective in achieving a reconfiguration of posts between the pillars in line with the policy of integrated care delivery. Nor has it proved effective in controlling pay and pay related costs in the health sector. Recourse to overtime, maternity replacement staff, locum and agency staff has meant that the HSE has reported no significant savings in 2008 on pay and pay related expenditure, despite the existing employment control framework in place and additional breakeven measures introduced by the HSE in an attempt to keep within budget.**

8. Administrative savings within the remit of the HSE

[TEXT WITHHELD – SECTION 21]

8.4 In addition to the 3% payroll efficiency in 2009, the strengthened employment control measures proposed for the health sector will include:

- A general embargo on the recruitment of management, administrative and clerical staff.
- New employment ceilings for 2009 and 2010 to reflect the targeted reductions in employment and any transfers of functions. Within the new employment ceilings scope for increasing the numbers in essential frontline occupations consistent with integrated care delivery.

- The numbers employed in the following grades may be increased to meet the requirements of integrated health care delivery: Hospital Consultants, Speech and Language Therapist, Occupational Therapist, Physiotherapist, Clinical Psychologist, Behavioural Therapist, Counsellor, Social Worker, Emergency Medical Technician.
- The numbers in all other grades will be decreased or held at their 2008 levels, as appropriate, to achieve the target reduction in employment numbers.

9. HSE Corporate & Population Health

<table>
<tr><th>Inputs</th><th>2008 Provisional Outturn
€m</th><th>2009 Allocation
€m</th></tr>
<tr><td>Corporate & Population Health
Pay
Non-Pay

Corporate Pensions &Repayment Scheme
Pay
Non-Pay</td><td>

286</td><td>597
246
351

313

290
23</td></tr>
<tr><td>Total
Pay
Non-Pay</td><td>817
507
310</td><td>910
536
374</td></tr>
<tr><td colspan="3">Staffing</td></tr>
<tr><td>Total
Corporate
Population Health</td><td colspan="2">3,907
540
3,367</td></tr>
</table>

Outputs		
	2008	2009
No calls to HSE Information Line No complaints No complaints dealt with in 30 days	78,172 3,900 2,197 (56%)	

Source: 2009 HSE Service Plan and 15 January 2009 Performance Management Report

Programme objective

9.1 HSE Corporate is responsible for driving corporate planning in the HSE and overall management of the HSE. The purpose of Population Health is to help the HSE plan and deliver health and personal social services that will maintain and improve the health of the whole population.

Service Delivery

9.2 Functions of HSE Corporate include managing finance, human resources, ICT systems, shared services, procurement etc. Services provided by Population Health include health intelligence, strategic health planning, health promotion, emergency planning, health protection, environmental health and suicide prevention.

Analysis

9.3 According to the HSE's performance report for January 09 the Health Corporate and Population Health 2008 budget accounted for €824mor 6% of total HSE expenditure. The breakdown of that expenditure between the various functions is as set out in the following table:

Function	Expenditure €m	% of Overall HSE Expenditure
National Shared Service	26.7	0.2
Estates	41.6	0.3
ICT	19.7	0.1
Procurement	13.6	0.1

Local Support (mainly pensions)	268.6	2.0
Population Health	102.1	0.7
Finance	64.5	0.5
Human Resources	190.5	1.4
CEO	17.3	0.1
Development and Technical Resources	80.1	0.6
Total	**824.7**	**6.0**

9.4 Some 35 former health board senior management availed of voluntary early retirement since the HSE was established. A December 2006 NTMA Review of the HSE's Banking and Treasury Functions found that there were 980 staff employed in finance and treasury functions who continued to operate under former health board structures with duplication of tasks throughout the country. It estimated that savings of €15m could have been achieved at the time in treasury administration functions. As there has been no major rationalisation of management and administrative staff as a result of the integration of the former health boards into a single national agency it is likely in the circumstances that these types of inefficiencies are replicated throughout the HSE.

9.5 **Options for savings**

1. [TEXT WITHHELD – SECTION 21] and a strengthened employment control framework to reduced the numbers employed in the Health Sector by 4,000 in 2009/2010 should significantly reduce the numbers of management administrative staff employed by the HSE, and in particular HSE Corporate. Estimated potential full year annual savings of €105m, €45m in 2012.
2. Eliminate all bonus payments [TEXT WITHHELD – SECTION 21]
3. Despite the focus to date on administrative efficiencies, the fact the HSE Corporate expenditure accounts for 6% of its total current expenditure should allow scope further savings in this area. A 5% cut in corporate expenditure would generate savings of €40m which would still leave Corporate expenditure at 5.5% of total HSE current expenditure.

[TEXT WITHHELD – SECTION 21]

Analysis of Programmes of the Department of Health and Children and the Office of the Minister for Children and Youth Affairs

10. Grants to Health Bodies

Inputs	2008 €m	2009 €m	WTEs
(i) Research bodies	41	39	129
(ii) National Lottery grants to Health agencies	4	4	-
(iii) Developmental, consultative, etc bodies	154	149	696
(iv) Office of Ombudsman for Children	2	2	15
(v) Food Safety Promotion Board (Nth/Sth)	7	7	30
(vi) National Treatment Purchase Fund	100	100	47
Total	**308**	**301**	**917**

Source: 2009 Budget and 2008 REV publications. WTEs from Department of Health & Children returns.

(i) Research Bodies

	2008 €m	2009 €m	WTEs
Health Research Board	37.375	35.767	84
National Cancer Registry Board	3.514	3.365	45
Grants to Health Agencies	3.985	3.985	-

Source: 2009 Budget and 2008 REV publications. WTEs from Department of Health & Children returns.

Health Research Board

10.1 The Health Research Board (HRB) is the lead agency in Ireland supporting and funding health research. The Board's aim is to improve people's health, build health research capacity, underpin developments in service delivery and make a significant contribution to Ireland's knowledge economy. It does so in two ways,

(1) through providing funding to support:

1. the development of people's research skills and capability
2. innovative projects and programmes
3. building infrastructure that will underpin a strong health research environment, and

(2) conducting research and managing national information systems in the areas of mental health, alcohol and drugs, child health and disability.

[TEXT WITHHELD – SECTION 21]

National Cancer Registry Board

10.3 The National Cancer Registry is wholly funded by the Department of Health & children and has been collecting comprehensive cancer information for the population of the Republic of Ireland since 1994. The information collected is used in research into the causes of cancer, in education and information programmes, and in the planning of a national cancer strategy to deliver the best cancer care to the whole population. This is being merged into the HSE in line with the Budget 2009 announcement.

10.4 **Options for savings**

1. [TEXT WITHHELD – SECTION 21]
2. Rationalisation plan resulting from 2009 Budget (See Administrative savings for Department of Health and Children) [TEXT WITHHELD – SECTION 20 & SECTION 21]

Grants to Health Agencies (Part funded by the National Lottery)

10.5 National Lottery funding is made available to voluntary organisations involved in the delivery of personal and social services. Such organisations are invited to apply for assistance under this heading. In the 2007 Appropriation Accounts 82 bodies are listed as having benefited from these grants. The amounts ranged from the highest €665,000 to the Irish Kidney Association to the lowest amount of €1,500 to a number of organisations. 15 organisations received grants of €100,000 or more,with the remainder receiving significantly lower amounts. The average payment in 2007 was less than €50,000. Payments under the scheme are the responsibility of the Finance Division in the Department of Health & Children.

10.6 **Scope for savings**

1. [TEXT WITHHELD – SECTION 21]
2. 46% of all part-funded Lottery subheads were funded by the Exchequer in 2008. Remove Exchequer element would provide a saving of €1.8m. It may take time to unwind grant assistance but should see full saving in 2010.
3. Reduce Exchequer element of grant by 20% - saving of €0.4m.

Development, Consultative, Supervisory and Administrative Bodies

10.7 A large number of Health related non-commercial organisations are funded from this subhead involving a wide range of activities, including regulatory and supervisory functions. These bodies range in size and scope from the National Cancer Screening Service (formerly BreastCheck) with an allocation of €51m to the National Social Work Qualification Board (€589,000). A full list of thebodies is set out below:

	2008	**WTEs**
	€m	
Irish Medicines Board	5.1	283
Postgraduate Medical & Dental Board	10.1	20
Food Safety Authority of Ireland	18.6	35
National Social Work Qualification Board	1.8	7
Women's Health Council	0.6	7
Institute of Public Health	0.7	
National Council for Professional Development of Nursing & Midwifery	1.6	13
Crises Pregnancy Agency	8.6	15
Pre-hospital Emergency Care Council	4.6	10
Mental Health Commission	9.0	43
National Cancer Screening Service	3.5	192
Office of Tobacco Control	21.0	14
Irish Health Services Accreditation Board	51.3	
Special Services Residential Board (CAAB)	2.5	15
Health Information & Quality Authority	16.8	42
Other	**4.6**	**-**
	154.2	**696**

Source: 2008 REV

10.8 Grants to developmental and consultative bodies are largely made up of pay-related costs. Accordingly, any general reduction in grants can be used to bring about a proportionate reduction in pay rates. The rationalisation of 17 agencies announced in Budget 2009 should also provide scope for further reductions - the Budget announcement will reduce the number of non-commercial bodies under the aegis of the Department of Health & Children from some 25 to 10.

10.9 **Options for savings**

1. [TEXT WITHHELD – SECTION 21]
2. Rationalisation plan resulting from 2009 Budget. (See Administrative savings for Department of Health and Children) [TEXT WITHHELD – SECTION 21]

Office of Ombudsman for Children

10.11 The Ombudsman for Children was established under the Ombudsman for Children Act 2002 to:

- provide an independent complaints and investigation handling service regarding actions by public bodies affecting children up to the age of eighteen;
- actively promote children's rights, including through national participation, communication and education activities; and
- conduct research, monitor law, policy, and practice, and provide advice to any Minister of the Government on any matter relating to the rights and welfare of children.

The Office has a budget of €2.37m in 2009 and a staff complement of 15 WTEs.

10.12 **Options for savings**

1. Merge with other Offices for Ombudsmen – saving of €10% should be capable of generate a saving of €0.2m

National Treatment Purchase Fund

10.13 The NTPF was established in 2002 to reduce long term waiting lists by procuring medical treatment for public patients who are waiting for an operation or procedure on a public hospital in-patient or day case waiting list for over 3 months. The initial intention was that spare capacity would be purchased from private facilities here and in the UK. Since its establishment in 2002 the NTPF has now arranged treatment for 135,000 patients.

Analysis

10.14 The 2007 Annual Report shows that administration costs including salaries was less than 5% of total budget.

There are concerns that the system is an expensive way of purchasing procedures privately that could/should be delivered by better utilisation of capacity in the public system. Most consultants in the private system also work in the public, the same consultant whose public patients have failed to obtain treatment in the public system is now likely to be providing that treatment for a fee within the private system. In his 2004 report the C&AG found that, in the cases he examined in detail, 44 per cent of procedures had been carried out in public hospitals and 36 per cent in the same public hospital from which the referral had come in the first place. In 2005, a new policy of limiting public hospitals' role in providing NTPF treatment was introduced when its share was capped at a maximum of 10 per cent of the total. The Public Accounts Committee (3rd Interim Report on the 2006 Accounts) found that the 80:20 split for private practice in public hospitals was largely ignored to the detriment of public patients. The 2009 HSE National Plan still has the achievement of this split as one of key performance indicators

10.15 **Options for savings**

2. [TEXT WITHHELD – SECTION 20]
3. Restrict NTPF activity to private facilities at home and abroad. Estimated saving €7.5 m

11. HEP C and Tribunal and Other Inquiries

	2008 €m	2009 €m	WTEs
(i) Statutory inquiries, etc	47	30	-
(ii) HepC Tribunal	76	76	5
(iii) State Claims Agency	25	60	-
	148	166	

Source: 2009 Budget. WTEs from Department of Health & Children returns.

Statutory & Non-Statutory Inquiries & Miscellaneous legal fees

11.1 This subhead covers general awards ands settlements arising out of the various inquiries ongoing under the aegis of the Department of Health & Children. The 2008 allocation was significantly higher than previous years to reflect payments made under the Lourdes Inquiry in that year.

11.2 **Options for savings**

Unless the various inquires are wound up, expenditure depends on progress on inquiries, legal awards and settlements.

Payments under Hepatitis C Compensation Tribunal Acts

11.3 The Hep C Tribunal was established under the Hepatitis C Compensation Tribunal Act 1997 to compensate people who contacted Hep C or HIV from infected blood products used for the treatment of haemophilia or as a result of receiving contaminated anti-D blood products.

11.4 To end 2008, some €900m has been paid out by the Tribunal in respect of compensation award, settlements, legal and administration costs. These costs have been running at some €75m for the past number of years. The tribunal is still dealing with primary claimants in respect of both Hep C and HIV infection while secondary claimants and appeals are also ongoing. Of the €75m annual cost, awards amount to some €65m, legal costs €9m with the balance (less than €2m) in respect of admin.

11.5 **Options for savings**

[TEXT WITHHELD – SECTION 20 (1)]

Payments to State Claims Agency for costs relating to Clinical Negligence

11.6 The Clinical Indemnity Scheme (CIS) was established in 2002 to rationalise pre-existing medical indemnity arrangements by transferring to the State, via the Health Service Executive (HSE), hospitals and other health agencies, responsibility for managing clinical negligence claims and associated risks. Under the scheme managed by the State Claims Agency (SCA), the State assumes full responsibility for the indemnification and management of all clinical negligence claims, including those which are birth-related. This subhead is set to increase as the State Claims Agency takes on more of the legal claims against the Health sector previously dealt with by private insurance providers. Claims are dealt with by the State Claims Agency and reimbursed by the Department of Health & Children from this subhead.

11.7 **Option for savings**

Expenditure is dependent on claims activity.

[TEXT WITHHELD – SECTION 21]

12. Early Childcare Supplement

Inputs	2008 Provisional Outturn €m	2009 Allocation €m
ECS Expenditure *Pay* *Non Pay*	506	397
Staffing		
Outputs		
	2008	**2009**
Number of Recipients	430,000	
Number of Payments	1.2m	

Source: 2008 REV, 2009 Budget and 2008 Department of Health and Children Output Statement

Programme Objective

12.1 This scheme was originally introduced in Budget 2006 to assist parents with the costs of childcare for younger children.

Service Delivery

12.2 It is delivered on an agency basis by the Department of Social and Family Affairs. Payment is made monthly through the post office system. It is paid on the second Monday of each month and it is paid in arrears. It is non taxable and being eligible for Child benefit qualifies for automatic entitlement to ECS payment.

Analysis

12.3 The Early Childcare Supplement is a universal non-means tested payment of €92 per month. A number of changes were made to the ECS in Budget 2009. From January 2009, the Early Childcare Supplement amounts to €1,104 per child per year paid in monthly instalments (not quarterly as previously) and the age threshold was reduced to 5 ½ years (it was 6 previously).

12.4 There remains a need for childcare supports particularly for parents on low incomes, returning to work or those who are in disadvantaged areas. The Community Childcare Subvention Scheme under the National Childcare Investment programme is already in place to assist with meeting childcare needs. This is a scheme that provides grant payments to crèches for parents in different bands of income and is designed to subvent childcare places for disadvantaged children. (See the National Childcare Investment Programme). Deadweight is also a factor with the ECS.

12.5 ***Options for savings:**

1. Abolish the ECS. Saving of 397m
2. Reduce the ECS. Reduce the ECS to the children aged 4½. (Children can start school at 4). This would result in a saving of €88m
3. Reduce the level of the ECS by 20% to €900 per year. This would result in a saving of €80m.
4. Introduce a means test to qualify for the ECS. This would have implications in terms of resources for implementing the means test. Savings of up to 20% should be possible €80m

*** The options available depend on decisions taken by the Government in the context of the February 2009 savings in public expenditure.**

<u>Risks</u>:

12.6 Given the changed labour market the justification for this scheme has lessened considerably. Nonetheless, any change that means taking money off existing holders runs the risk of voluble resistance.

13. National Childcare Investment Programme (NCIP).

Inputs	2008 Provisional Outturn €m	2009 Allocation €m
National Childcare Investment *Pay* *Non Pay*	74	74
Staffing		
Outputs		
	2008	**2009**
Number of Childcare Places (Annual)	11,000	

Source: 2008 REV, 2009 Budget

Programme Objective:

13.1 The primary objective of policy in this area is to create a supply of affordable childcare. The NCIP and any successor programmes aim to increase the supply of affordable childcare places to 100,000 by 2016. (Towards 2016). In addition to dealing with the overall supply of childcare the NCIP seeks to target provision of childcare in areas of disadvantage either through provision of trained staff to crèches and/or payment of subvention to crèches/children. A review of the NCIP is expected to take place this year.

Service Delivery:

13.2 The scheme assists with the staffing and other operating costs that focus on disadvantage. It is delivered through community and private service providers. The Community Childcare Subvention Scheme (CCSS) was altered in 2007 to focusing supports on children rather than on crèches.

13.3 The NCIP also supports 33 County Childcare Committees (CCC) and a number of voluntary organisations which underpin the administration and quality services in the sector with funding of €15.4m in 2007.

Analysis:

13.4 The VFM review of the Equal Opportunities Childcare Programme (predecessor to NCIP) concluded that there was some duplication of services between CCC's and voluntary agencies and their roles should be more closely defined.

13.5 The objective of the scheme is to subvent community based not – for – profit childcare services to enable them to provide care to disadvantaged families. It works by allocating funds across three bands depending on the parent's circumstances.

- Band A is for children whose parents are on social welfare and this is per week.
- Band B is for children whose parents are in receipt of FIS or childcare subsidies.
- Band C is for children whose parents are on low income but outside of the boundaries of Bands A and B.

13.6 Transitional arrangements are in place to ensure that there is support for existing services which would otherwise face a significant decrease in their existing level of support. Crèches will receive 90% of their 2007 funding in 2008, 80% in 2009 and 70% in 2010.

13.7 Options for savings:

1. Abolish the transitional provisions under the scheme. If 20% of crèches benefit from the transitional arrangements there would be a saving of €2m per year approximately.
2. Alter the means test by eliminating Band C as the Bands A and B are sufficient. If 10% of the parents fell into band C, this would create a saving of €5m
3. Rationalise the administrative structures of the (33 CCCs and voluntary bodies). Estimated saving of €3m.

Risks:

13.8 As there are 33 County Childcare Committees with an average of 22 members each. comprised of key stakeholders in each county any changes to the scheme are likely to be vociferously opposed.

Analysis of HSE programmes

14. Children and Families

Inputs	2008 Provisional Outturn €m	2009 Allocation €m
Children and Families *Pay* *Non Pay*	**570**	**582**
Staffing		
Children and Families Total	2,800	

Outputs		
No. in residential care	426	426
No. in foster care	3,196	3196
No. in care of relative	1,530	1530
Other placements	182	182
% of children with written care plan	78%	82%
Pre school visits	2145	2145
Child Abuse reports	20,000	
Applications to be taken into care	2,000	

Source: 2009 HSE Service Plan and 2008 Department of Health and Children Output Statement

Programme Objective

14.1 The aim of this programme is to promote and protect the well being of children and families, particularly those at risk of abuse and neglect, by having children cared for in appropriate care settings. An additional objective is to reduce the number of children in residential care from 7% currently to 5% by 2013.

Service Delivery

14.2 There has been a rationalisation of special arrangements and maximising the occupancy of special units. This has led to a corresponding significant increase in the

number of children being placed in the care of relatives and foster care services with the associated increase in costs of that service because of the increased need for care planning, standardisation of assessments and provision of community based services for children with additional needs.

Analysis

14.3 Care requirements for children involve a high level of legal and administrative compliance at all stages of the process. The HSE work in this area arises from its legal obligations under the Child Care Act 1991, Children Act 2001, 1995 Child Care Regulations and the UN Convention on the Rights of the Child ratified in 1992. Services provided include early year services, family support services, child protection services, alternative care, services for homeless youth, search and reunion services, psychological services, child and adolescent psychiatric services, staff training and development, registration and inspection of children's residential centres in the voluntary sectors and monitoring of children's residential services in the voluntary and statutory sectors.

14.4 The opportunity costs of not responding appropriately could be significantly higher over the medium/long term both in terms of direct finance (through possible legal actions) and through societal costs. On foot of High Court judgements delivered in July 2007, a review of special care and high support provision is underway in the HSE.

Options for savings

14.5 [TEXT WITHHELD – SECTION 22] The objectives of reducing the numbers in out of home residential services remain valid and the focus should be on the optimum configuration of services to make the best use of available resources in developing services in this area.

15. Primary Care Programme

Inputs	2008 Provisional Outturn €m	2009 Allocation €m
Primary care *Pay* *Non-Pay*	610	623
Primary Care Reimbursement Service	2,461	2,455
Medical Card Scheme	*1,774*	*1769*
Long-term Illness Scheme	*135*	*134*
Drug Payment Scheme	*314*	*314*
Dental treatment Scheme	*61*	*61*
Ophthalmic Scheme	*22*	*22*
Miscellaneous, including admin	*155*	*155*
Total *Pay* *Non-P ay*	**3,071**	**3,078**
Staffing		
Primary Care **Total**	16,765	

Outputs		
Primary Care	104 Primary Care Teams (PCTs) 106 PCTs in development	210 Primary Care Teams (PCTs) 100 PCTs in development
Primary Care Reimbursement Service		
Medical Cards	1,342,966 persons covered	1,423, 830 persons covered
Long-term Illness Scheme	556,873 claims 2,565,944 items (drugs and non-drugs)	592,885 claims 2,742,951 items (drugs and non-drugs)
Drug Repayment scheme	3,814,934 claims 14,455,916 944 items (drugs and non-drugs)	4,183,687 claims 15,944,205 944 items (drugs and non-drugs)

Source: 2009 HSE Service Plan and 5 December Performance Monitoring Report.

Programme objective

15.1 Under the integrated health care strategy being pursued by the HSE a basic objective is that 90% of health and personal social services will be provided through primary care teams (PCTs) and Health and Social Care Networks. Acute services will be delivered in the acute hospital setting.

Service Delivery

15.2 There are some 100 primary care teams (PCTs) in operation, one fifth of the target for 2011 under the HSE‘s primary care strategy. PCTS are multi-disciplinary teams comprising GPs, nurses, midwives, home helps, physiotherapists, occupational therapists and administrative personnel. The wider health and social care networks comprise speech and language therapists, social workers, community pharmacists, dieticians, chiropodists, social workers, psychologists, mental health and disability services etc. The HSE has indicated that there are over 500 GPs (around one quarter of GPs under the GMS) participating in PCTs. The HSE plans to provide PCT facilities through a combination of traditional Exchequer capital funding in socially disadvantaged areas and partnership with the private sector though the leasing of premises in retail developments etc in other areas.

Analysis

15.3 The 2006 Report on the Primary Care Reimbursement Service indicated more than 5,800 service providers - GPs (2,315), Pharmacists (1,530), Dentists (1,414) and Optometrists (552) were providing services under the GMS. They are generally remunerated through a contract encompassing a fees framework essentially based, as appropriate, on capitation rates or fee per item dispensed. Payments to GPs amounted to €404m or 19 % of expenditure on the primary care reimbursement service, Pharmacists €1,365m or 66%, Dentists €55m or 2.7% and Optometrists €18m or 0.9%, payments to wholesalers amounted to €207m or10 % and administration costs amounted to over €14m or 0.7%. Some 53.4% of the population benefited under the primary care schemes.

Primary Care Teams (PCTs)

15.4 The delivery of PCTs and health and social care networks is essential to the delivery of integrated health care and an essential prerequisite to the rationalisation of acute hospitals and freeing up resources in the hospital sector. Primary care and the delivery of care in the community are generally regarded as more cost effective and efficient than having people with non acute medical needs clogging up emergency departments and

occupying expensive hospital beds. It is considered, therefore, that it would be a false economy to seek to make savings on the roll-out of PCTs. The focus here should be on the optimum configuration of services to make the best use of available resources in developing the service.

Primary Care Reimbursement Service

15.5 The main components of the primary care service are the Medical Card Scheme, the Long Term Illness Scheme and the Drug Payment Scheme. The basic objective of the schemes is to provide access to health and personal social services based on medical need without causing undue hardship.

Medical Card Scheme €1,486m

15.6 There are over 1.343m persons covered by medical cards (including some 95,000 GP Visit only cards) and, as unemployment increases and the population grows, the number is projected to grow by around 1,500 per week. The annual average cost of a medical card is approximately €1,650 (including capitation fee anddrugs cost). This rate of growth in medical card coverage is unsustainable.

15.7 A medical card eligibility review group is currently reviewing medical card eligibility with an Exchequer neutral mandate in regard to cost. Eligibility under the scheme is determined by Income Guidelines set by the Minister for Health and Children which, apart from the Over 70s medical card arising from Budget 2009, has not been revised since June 2006 when the rates for single people, couples and dependent children were set below the basic rate for unemployment assistance (jobseekers) allowance. Eligibility is based on net income (except for the over 70s). Under HSE guidelines for the operation of the scheme, there are a number of income disregards (mainly social welfare, education and training allowances), partial assessment of savings and assets held by individuals and additional allowances in respect of household expenses such as rent, mortgage costs, childcare and travel to work (the treatment of assets and additional allowances for household expenses are not related to medical need and are either not allowable for social welfare purposes or are more generous than their social welfare equivalent). HSE deciding officers also have additional discretion on medical and hardship grounds to award medical cards. In practice under these arrangements, all people whose sole income is from social welfare automatically qualify for a medical card regardless of medical need and there are significant numbers of middle income earners in

employment and single people rather than families with medical cards. The operation of the medical card income guidelines and the discretion available to the HSE is resulting in cards being granted on grounds other than medical need and affordability and is undermining the original objectives of the scheme. As the medical card is a passport to accessing other services such as childcare, school books scheme etc. the generous application of eligibility conditions for the medical card is pushing up the cost of other public services as well health services.

15.8 As access, particularly in socially disadvantaged areas, is a common concern it is considered that there is little or no scope for reducing the number of service providers such as GPs and pharmacists. Any reduction in eligibility coverage under schemes will have implications for the income of service providers. The failed attempt to date to reduce the wholesale margins payable to pharmacists by the HSE and to save €120m in 2008 and the experience of the ending of the automatic entitlement to the Over 70s Medical Card have shown there would be strong resistance from service providers for any proposals of this type.

15.9 Options for savings

However, there is scope for savings if structural reform of the conditions of eligibility is undertaken:

1. [TEXT WITHHELD – SECTION 21]
2. Invite tenders by open competition to provide services under the GMS as opposed to engaging with existing service providers to renew contracts for existing services. This could increase competition in regard to the supply of services. For instance, private sector health companies, groups of existing suppliers or multi-national pharmaceutical chains might compete to supply and could possibly generate significant savings. This option is difficult to cost but savings of up to, say 15% or € 370m approximately, might be achievable from such an approach.
3. A possible option would be to revise the income guidelines to the basic rate of social welfare (jobseekers allowance), so that all existing non-medical allowances and HSE discretion are removed and replaced, instead, with a variable allowance based on medical needs ranging from a substantial allowance for those with predefined chronic illnesses to a small allowance for episodic illnesses. It is difficult to cost this option but, for instance, preliminary analysis (as part of the Medical Card Review Group) of income from a HSE Survey of some 950 card

medical records would indicate that 47% of card holders would loose their card if the Jobseekers income threshold, medical card child allowance and no additional allowances (as in mortgage, rent childcare travel etc.) were applied for medical eligibility purposes. Some additional allowance for medical expenses would be required to meet the objectives of a medical card scheme based on medical need. This would reduce the numbers that would be ineligible, but it should be possible to make savings, of say up, to 20% on the number of card holders. Estimated saving of [TEXT WITHHELD – SECTION 20 (1)] €70.5m if Drug Payment Scheme payment threshold remains unchanged ([TEXT WITHHELD – SECTION 20 (1)] €161+ €100 by 270,000 = €70.5m)).

4. Severely restrict HSE discretionary cards and reduce the number of allowances or cap them. A saving of €150m (or 8%) could be achieved if this target was set.
5. Introduce a charge for card holders for all items dispensed. Based on (latest available data) 2006 data when 41m prescription items were dispensed a charge of, say €2.50 per item, would generate savings of over €100m

Long Term Illness Scheme €135m

15.10 People (other than medical card holders whose costs are covered under that scheme) suffering from certain prescribed conditions (*Acute leukaemia, Cerebral Palsy, Conditions from Thalidomide, Cystic fibrosis, Diabetes Insipidus, Diabetes Mellitus, Epilepsy, Haemophilia, Hydrocephalus, Mental Handicap, Mental Illness aged under 16 , Multiple Sclerosis, Muscular Dystrophies, Parkinsonism, Phenylketonuria, Spina Bifida*) may obtain, without charge, necessary drugs, medicine, medical and surgical appliances for the treatment of that condition. Demand based on population growth, the incidence of illness and increases in drug and appliance costs are driving costs under this scheme.

15.11 Options for savings include:

1. [TEXT WITHHELD – SECTION 20]
2. [TEXT WITHHELD – SECTION 20]
3. Introduce a charge for items dispensed. A charge of, say €5 per item, would generate savings of some €13m

Drug Payment Scheme €314m

15.12 Under this scheme, the HSE, without regard to means, meets the costs of approved prescribed drugs, medicines and certain appliances for use by that person or family (other

than medical card holders whose costs are covered under that scheme) over and above a threshold of €100 per month (having been increasedby €10 in Budget 2009) . As in the case of the Long Term Illness Scheme, this is a demand led scheme with costs being driven by population growth, the incidence of illness and drug and appliance costs.

15.13 Options for savings include:

1. [TEXT WITHHELD – SECTION 20]
2. [TEXT WITHHELD – SECTION 20]
3. Raise the monthly threshold, by say €20 per month.This would generate savings of around €50m.

[TEXT WITHHELD – SECTION 20 & SECTION 21]

16. Acute Hospitals (including cancer) Programme

Inputs	2008 Provisional Outturn €m	2009 Allocation €m
Acute Hospitals (net)	**4,660***	**4,657 ***
Statutory Hospitals		3,241
Pay		*2,322*
Non Pay		*919*
Voluntary Hospitals		2,401
Pay		*1,646*
Non Pay		*754*
Total	**5,285***	**5,642***
Pay	*3,696*	*3,968*
Non-Pay	*1,589*	*1,673*
Staffing		
Total	**53,200**	

*** Difference relates to how own income is accounted for**

Outputs		
	2008	**2009**
Acute Hospitals		
No of outpatients	3,248,091	3,233,000
No of emergency presentations	1,222,682	1,223,000
No of patients discharged	602,237	573,428
No of Births	73,700	76,880
Average Length of Stay	6.2 days	5.9 days
Public as a % of all patients	75%	80%

Source: 2009 HSE Service Plan and 5 December Performance Management Report

Programme objective

16.1 The objective of the programme is to provide pre-hospital emergency care and a wide range of services including assessment, diagnosis, treatment and rehabilitation for people in need of acute care.

Service Delivery

16.2 Acute care is delivered through 50 hospitals and 8 hospital networks. The National Hospitals Office in the HSE has overall responsibility for the planning and management of acute hospitals. In line with best practice, the HSE is seeking to provide acute complex healthcare, particularly for emergency medicine, complex surgical services and critical care services in hospitals with high volume activity.

Analysis

16.3 The range and quality of services available in acute hospitals have improved over the years, including reductions in waiting times for treatments. Despite this, the hospital service is characterised by overcrowding in emergency departments, trolleys on corridors and delayed discharges, especially at winter peak times.

16.4 The existing services provided and the resources allocated to the different hospitals are heavily influenced by historical considerations. Staff numbers in the hospital pillar have grown significantly since the HSE was established. The larger growth in employment has occurred in Other Patient and Client Care, 3,700 or 25%, Health and Social Care Professionals, 2,918 or 23%, Medical/ Dental, 1090 or 15%, and Nursing 3,585 or 10%, while Management/Administrative Staff grew by 1,771 or11% and General Support Staff fell by 971 or 7%. This growth in numbers masks a mismatch between the numbers and types of staff required to deliver integrated health care and making the optimum use of resources. For instance, WHO statistics show that Ireland (at 195 nurses and midwives per 10,000 population has more than twice the average of 78 per 10,000 population), while we have less hospital consultants and professional therapeutic grades than we need. At the same time, there are hospital consultants and other professional staff who are either underemployed in small local hospitals providing around the clock services where demand does not warrant it or where they have insufficient expertise and experience to provide the necessary specialist service required in the most safe way. Further cost considerations are the escalating costs of drugs and high tech

treatments and the use of public facilities for private practice, an average of 75% public usage in 2008. While the new contracts for hospital consultants negotiated in 2008 are designed to stop the practice, consultants have in general exceeded the 20% ceiling on private practice which they are allowed to undertake in public hospitals. Performances in regard to key indictors such as the number of patients treated, average lengthy of stay etc vary significantly across the hospitals due to a combination of these factors.

16. 5 Vested interests within the hospital system and external to it, act as impediments to reform and the proper development of integrated health care.

16.6 The HSE has commissioned [6] reviews of acute hospital services by external consultants *(Acute Bed Capacity, Patient Transport, HSE South, HSE mid West, the Maternity Hospitals in Dublin and New Regional Hospital in the North East)* and two internal reviews (*Acute services in the Greater Dublin Region and Review of Services in the Midlands)***. (See appendix 2).** The PA Consulting Report on Acute Beds concluded under “A Preferred Health System” (now termed integrated health care) that instead of providing an estimated 19,800 beds or so in 2020 under current practice there could be a reduction in beds to around 8,800, less than then current level of 12,778 if integrated health care was implemented in Ireland. (In addition to the public beds there are around 2,000 private hospital beds (not counting public beds being used for private patients) in Ireland). The PA Consulting Review estimated that the operating cost per day of acute beds ranged from €2,600 for a Critical Care Bed €1,917 for an Inpatient Bed in a major teaching hospital to €2,000 and €825 respectively in a major regional hospital. A Day Case Bed was priced at €588 per day in both settings while a Medical Assessment Unit was estimated to cost €1,050 per day.

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16.7 The reconfiguration reviews, broadly speaking, involve specific proposals for reconfiguration of services between hospitals based on critical mass and best practice, such as speciality teams and the concentration of certain acute services in a single regional hospital. In some cases, the reports point to serious concerns about patient safety. They also involve the appropriate development of other services in local hospitals and the community in the context of the integrated care model. With the exception of cancer services, progress on the implementation of the reconfiguration of services has been slow.

16.8 At end 2008, the number of hospitals providing specialist cancer services will under the new National Cancer Control Programme have been reduced from 33 to 10 and the target of concentrating services in 8 specialist services is expected be achieved in early 2009. The first phase of the National Plan for Radiation Oncology is expected to be completed by 2010 and the second phase, involving the roll out of radiation therapy facilities on a PPP basis, is expected to be delivered by 2014. A review of the utilisation and cost of chemotherapy drugs has also been initiated.

16.9 The main approach of the HSE to date to securing efficiencies in hospital services has been working with individual hospitals to develop and implement better patient management and discharge planning by identifying and disseminating best domestic and international practices. The measures being implemented include planning individual patient journeys at time of admission, less frequent return visits to outpatient departments etc. The scope for securing more efficiency from this approach is likely to diminish over time and more radical structural reform is required to accelerate the pace of change. [TEXT WITHHELD – SECTION 21]. However, real configuration of services along the lines of that taking place in cancer care is required. This will require a more coherent approach to the planning and provision of hospital services but also to the necessary alternative primary and community care services to facilitate reconfiguration of hospital services. Alternative services must, at minimum, be put in place in tandem and be seen to be working before existing services are discontinued (See analysis of capital programme).

Options for savings

16.10 Possible options for savings include:

1. Prioritising the reconfiguration of service reports and their recommendations based on established needs, patient safety and what can be delivered within existing current and capital resources in the medium term and implementing these priorities on a phased basis, instead of trying to tackle everything at the same time. It is difficult to quantify the savings that would arise from such an approach but it should produce significant savings in the medium term, [TEXT WITHHELD – SECTION 20 & SECTION 21] However, the next savings would be considerably less as much of these resources would have to be reinvested in primary and community care to meet needs on an integrated care basis

There is likely to be strong local and internal resistance to any reconfiguration of hospital services no matter how it is managed.

2. Introduce mandatory protocols which require hospitals and clinicians to prescribe generic medicines, off patent drugs and value for money high tech treatments consistent with good patient care. This would be likely to be resisted by clinicians as an unwarranted interference in their professional discretion and the HSE will argue that this will happen anyway when they introduce clinical directors under the new consultants contract deal. Savings of at least 5% on non- pay costs should be possible - €80m.
3. Progressively move towards the full economic cost of charging for private facilities in public hospitals. . This will impact on private health insurance. As provided for in the 2009 Budget, a further 20% increase in the cost of such a private and semi-private bed in public hospitals would produce estimated Exchequer savings of €70m in 2010.
4. Increase A&E Charges for non-medical card holders who present at A&E Departments without a letter from their GPs (Budget 2009 increased the charge from €66 to €100) and public hospital inpatient charges (increased from €66 to €75 in Budget 2009) by 10% - saving of €4m.

Risks

16.11 The options involving reconfiguration of services and the introduction of drug/ treatment protocols are high risk and may offer limited prospects for savings in 2010. Increased charges would be considered to be of medium risk. They would require new regulations/statutory instruments.

17. Disability and Mental Health Programme

Inputs	2008 Provisional Outturn €m	2009 Allocation €million
Programme Expenditure		
Disability Services	1,485	1,508
Mental Health	995	1,022
Total	**2,480**	**2,530**
Staffing		
Disability Services	15,725	
Mental Health	8,546	
Total	**24,271**	

Outputs	Project Outturn 2008	Expected Activity 2009
Disability Support Services -Intellectual Disability and Physical and Sensory		
Day Services	20,886	20,886
Residential & Respite Places	9,219	9,219
No of Hours of Personal Assistance /Home Support	3,200,000	3,200,000

Source: HSE National Service Plan 2009 and management performance reports. Employment numbers are September 2008

Service Delivery

17.1 Services to people with disabilities are provided either directly by the HSE or, in partnership with non-statutory voluntary service providers.

17.2 Mental Health services span all life stages and are provided through a range of primary and community based services as well as specialised services for Children and Adolescents, Adults and Older Persons. According to the HSE National Service Plan for 2009 there are 61 registered approved centres under the Mental Health Act 2001 for the admission and treatment of acutely ill patients approximately 800 centres that provide community based services. There are currently 1,892 acute inpatient beds in mental

health services throughout the country and 721 long stay beds and that an additional 366 inpatient beds are provided nationally in the form of continuing care, old age psychiatry and rehabilitation.

Programme Objectives

17.3 Services for persons with disabilities seek to enable persons with a disability to achieve their full potential and maximise their independence.

17.4 Mental Health services seek to promote good mental health and provide appropriate support to and interventions for, people with mental health problems. A person is regarded as having a disability if that person has a substantial restriction in their capacity to carry on a profession, business or occupation or to participate in social or culture life by reason of enduring physical, sensory, mental health, or intellectual impairment.

Analysis

17.5 Part 2 of the Disability Act, 2005 provides people with disabilities with an entitlement to an independent assessment of health and education needs and a statement of services that will be provided to them having regard to available resources. Part 2 of the Act commenced for children under 5 years from 1st June 2007 and will be commenced in respect of children aged 5-18 years in tandem with the implementation of the Education for Persons with Special Educational Needs (EPSEN) Act 2004. In the light of the current financial circumstances, further implementation of the two Acts has been deferred.

17.6 According to the Census of Population, 2006 9.3% of the population or 393,800 persons reported a disability. The National Disability Survey (NDS), 2006 which was drawn from persons who reported a Disability in the Census, resulted in an estimated disability prevalence of 8.1% or 325,800 of the population. Of the persons reporting a disability in the NDS, 24% reported the highest level of severity which meant that their disability prevented them from doing everyday activities. A further 43% reported a lot of difficulty, and 31% reported having a moderate level of difficulty with everyday activities. The 75 and over age group accounted for 22% of all persons with a disability, while the 65-74 age groups accounted for a further 14%.

Trends in number of persons registered on the National Intellectual Disability Database and National Physical Sensory Disability Database 2004-2007

Year	Number of Persons Registered NIDD	Number of Persons Registered NPSDD
2007	25,613	29,089
2006	25,518	27,056
2005	24,917	24,511
2004	25,416	19,677

Source: National Intellectual Disability Database Committee and National Physical Sensory Disability Database Committee Annual Reports 2004-2007

17.7 The 2007 Annual Reports of the National Intellectual Disability Database (NIDD) Committee and the National Physical Sensory Disability Database (NPSDD) Committee indicate that estimated 24,898 people with intellectual disability are in receipt of health services and 24,852 people with physical and sensory disability are accessing at least one of the following service groups: therapeutic intervention and rehabilitation services, personal assistance and support services, and respite, day and residential services.

17.8 According to the report of the expert group on mental health policy *'A Vision for Change, 2006'* from a population perspective, the number of people affected by mental health problems at any one time is high. About one in four individuals will have a mental health problem at some point in their lives. The HSE National Service Plan 2009 indicates that there were approximately 16,230 numbers of admissions to acute mental health inpatient units (adult and children) in 2008. The expected activity in 2009 is 15,905 admissions.

17.9 Allowing for differences in relation to determination of the prevalence of disability and the lack of good quality information in regard to the needs of those with disability and mental health and the level of services being provided , it is clear that there are substantial unmet needs in this area.

Costs for Disability Support Services for Intellectual, Physical and Sensory disabilities are estimated as follows:

Day Services	€10m provides 500 day places
Residential Places	€16m provides 200 residential places
Respite Places	€5m provides 60 respite places
No of Hours of Personal Assistance /Home Support	€5m provides 200,000 Personal Assistance / Home support

Source: HSE Performance Monitoring Report September 2008

17.10 The Comptroller and Auditor General *(C&AG VFM Report 52, 2005)* found that in excess of 600 community and voluntary agencies are being funded by the State and that there was no proper audit of monies spent, services provided or measurement of outcomes achieved. It also found that the approach to the funding non-profit voluntary organisations was based on incremental increases and the cost of new placements rather than a contested procurement of services.

17.11 The most significant portion of costs associated with Long-Stay Residential Care for Adults are staff based with 87% of the €249m total cost of service directly attributed to staffing costs. *Value for Money and Policy Review of the Efficiency and Effectiveness of Long- Stay Residential Care for Adults within the Mental Health Services (final draft Dec 08).* The Report highlighted significant differences in the utilisation of staffing across mental health catchment areas with wide regional variances in the WTE availability and skill mix deployment in similar care environments leading to significant difference in costs per bed per day.

Options for savings

17.12 Budget 2009 provided for a 1% efficiency dividend from voluntary disability bodies. In the light of the scale of the unmet demand, the focus on the disability and mental health programme should now be on making the best of the resources available rather than reducing the allocation of resources. [TEXT WITHHELD – SECTION 21] The HSE should also ensure that there are robust and appropriate service level agreements in place with non profit service providers which contain clear specifications of services

being procured and desired levels of service which would enable performance monitoring and evaluation and that these are monitored.

18. Care of Older People

Inputs	**2008 Provisional Outturn €m**	**2009 Allocation €m**
Total	**1,846**	
Pay		
Non Pay		
Long Stay Hospitals	*668*	
Community Residences and daycare	*610*	
Nursing Home Subventions	*326*	
Home Help Services	*181*	
Other Services	*51*	
Fair Deal		*55*
Staffing		
Total	10,293	

Outputs		
Long term Care		
Subvention (individuals)	9,079	9,100
Enhanced subvention	4,883	4,900
Statutory inspections of nursing homes	872	872
Home and Community based support	54,500 clients in receipt of 11.96m homehelp hours 8,700 clients in receipt of 4,700 Homecare packages	54,500 clients in receipt of 11.98m homehelp hours 8,700 clients in receipt of 4,700 Homecare packages
No. of public and voluntary beds	10,543	11,243

Source: Revised Estimates Volume 2008,Budget 2009 and 2009 HSE National Service plan. D/Health estimates of bed numbers and cost for Fair Deal

Long term Care

Programme Objective

18.1 The programme objective is to enable older people to maintain their health and well-being, as well as to live active and full lives, in an independent way in their own homes and communities for as long as possible. The Long Term Care Working Group Report set a target of 4% of those over 65 in long term care recognising that there was scope to reduce the 30% of individuals in long term care who were of medium and low dependency.

Service Delivery

18.2 The service is delivered through the public and private systems. In total, there are an estimated 22,785 long term care beds in the system 14,810 of which are private beds and 7,975 of which are public beds. Supply and demand varies by region with indications that the shortage of supply of beds is most acute on the east coast. The introduction of nursing home standards later this year can be expected to put further pressure on supply of beds in the public and private sectors with consequent knock on demands on capital budgets.

Analysis

18.3 The primary driver of expenditure in this area is an ageing population. In 2002, there were 436,001 people aged over 65. This figure is set to increase to 1,145,300 in 2036 i.e. up by 260% in the next 35 years. (Long term Care Working Group Report). In addition, the price of nursing home care can be expected to increase in real terms by 3.8% per annum (OECD). [TEXT WITHHELD – SECTION 20 & SECTION 21 (1) (c)]

18.4 State support for nursing home care is provided on different basis in the private and public sectors. For publicly provided beds individuals contribute a maximum 80% of the State pension towards the cost of their care (around €150 per week compared to an estimated cost of €1.300 per week). Entry to care is non-means tested. For private beds, individuals pay for their own care (around €800 per week) and the State makes a means tested contribution of a maximum €300 to the costs of care. Enhanced subvention, which allows the HSE some discretion, can be paid in certain circumstances. Because of this difference in costs there are incentives to remain in acute settings (the bed blocking problem) as a means of access to a public nursing home bed. Demographics will make this policy approach financially unsustainable over the medium/long term.

18.5 The Fair Deal legislation currently passing through the Oireachtas will replace the two schemes above with a needs and means test and equalise the dichotomy that exists between the public and private systems. The State will agree to underwrite the complete costs of care. The state also will loan individuals the portion of their contribution to care costs that arises due to their primary residence (15% - 5% of the value for 3 years). The administrative arrangements are currently being put in place to run the scheme which is expected to be operational in the second half of 2009.

18.6 Options for savings include:

[TEXT WITHHELD – SECTION 20]

1. Increase the percentage of care costs under the Fair Deal contributed by an individual from their residence to 7.5% for three years to a total 22.5% (from 15% currently). Saving of €75m per annum.

Home Services & Homecare Packages

Programme Objective

18.7 Community based care systems are crucially important to reducing the percentage of individuals in inappropriate long term care beds given the ageing population. Homehelp hours and homecare packages provide individuals with support in their home in the community to ensure individuals are being cared for appropriately in appropriate settings.

Service Delivery

18.8 Homehelp hours usually assist people with normal household tasks, although they may also help with personal care. **Homecare packages** provide a range of services, including nurses and therapists. Individuals are referred by health professionals and a needs assessment is completed with appropriate services being provided.

Analysis

18.9 Currently, the HSE are legally obliged to provide the services of a public health nurse (but not other professionals) free of charge in the home under Section 60 of the 1970 Health Act. Other services can be charged for. (HSE have the legal authority to charge for additional services under section 61 of the 1970 Act “or at such charge as the Minister considers appropriate”). The current practice is that homehelp hours are

generally means tested (even for those on a medical card) and individuals may have to make a contribution/pay for the costs of care. However, there is no charge for Homecare packages. This situation can in practice be further exacerbated by the lack of clear distinction as to what constitutes homehelp hours and homecare packages. An evaluation of the Homecare packages scheme is currently underway by external consultants.

18.10 Options for savings include:

1. Charge the full economic cost of Homecare packages to all recipients - estimated savings of €120m
2. Charge the full economic cost of Homehelp packages to all recipients - estimated savings of €180m.
3. For Homecare packages introduce a means test to end eligibility for the top 20% of income earners, providing an estimated saving of €24m.

Risks

18.11 The vulnerable nature of the client group makes changes across the policy programme high risk. Eligibility legislation would be required to provide a statutory basis for determining entitlements and charging regimes for the homecare and homehelp packages further deferral of the Fair Deal would be high risk and it would put pressure on nursing home subvention costs. It would also require legislative change.

19. Health Capital Programme

Overview

Capital Programme	**2008 Estimates € million**	**2009 Estimate € million**
HSE	594	465
Health and Children	20	15
Office Minister for Children & Youth	102	60
Vote Group Total	**716**	**540**

19.1 The 86% of the Health Vote Group capital is allocated to the HSE to fund the provision of Health Care facilities under the HSE's capital plan. Under the reprioritisation of NDP capital expenditure in favour of economic infrastructure investment health capital was reduced by €176m in 2009 or the annual commitment under its 5 year multi annual envelope by €200m per annum.

19.2 The 2009 draft HSE capital plan has been submitted to the Department of Health and Children for approval but it has not yet been submitted to the Department of Finance for our approval. Assessment of the scope for savings in health capital is therefore based on the HSEs 2008 capital plan, as approved, and the targeting of health capital for savings in the interim in the light of the deterioration in the public finances.

Objective

19.3 The basic objective of HSE capital investment is to support the development of integrated health care provision in line with best international standards. Office of the Minister for Health and Children capital is used to fund the provision of childcare facilities under the National Childcare Investment programme to support the target of 50,000 childcare places by 2010.

Analysis

19.4 In 2008, the HSE identified capital requirements of €6.6 billon over the period 2008-2013. It is proposed to spend €5.02 billion. They had €4.3 billion available under the NDP, comprising €3.9 billion Exchequer and €415million in PPP funding. The plan

assumed that funding would be available from the proceeds of the sale of surplus properties €446 million, Philanthropy €152 million and NDFA loan refundable from the sale of the Central Mental Hospital €130 million and though innovative arrangements such as leasing primary care facilities from the private sector. In addition, the HSE had an allocation of some €40m for ICT capital.

19.5 Under the 2008 capital plan there were over 400 projects under construction, in design and planning as follows:

	All Projects	**Hospital**	**PCCC**	**Medical Training**
Under construction	135	70	63	2
Design	124	53	71	-
Planning or brief Development	167	61	106	-
Total	**426**	**184**	**240**	**2**
Value in €m	*544*	*239*	*293*	*12*

In its initial years the HSE under spent its capital and used its capital to balance overruns on the current side. In recent years, it has spent its construction capital on capital projects, albeit a significant proportion on minor capital projects and continues to under spend on ICT capital despite have an ICT infrastructural deficit. The saving on ICT capital in 2008 was €20m.

19.6 The 2007-2008 National Development Plan provided for the construction of 4 major hospital projects. Despite unprecedented levels of capital resources being available under this and the previous NDP, the HSE has scheduled works to begin on these hospitals as follows:

	Mater Adult	**National Paediatric Hospital (also Mater)**	**National Rehabilitation Hospital**	**North East Regional Hospital**
Cost €m	S.20	S.20	S.20	S.20
Period of Construction	S.20	S.20	S.20	S.20

19.7 The rationale for the continued development of these major projects is unclear given:

- the delays to date in progressing them
- The PA Consulting Report conclusion that there are sufficient acute beds in the system
- The reduction in HSE capital allocation to reflect to new economic reality
- The fact that the provision of step down community nursing beds, primary care team facilities and medical assessment units are an essential prerequisite to breaking the log jam in acute hospitals and the delivery of integrated care.

19.8 There are substantial unmet needs in regard to A&E Department works, the provision of facilities for primary care teams and residential care beds for the elderly. The 2008 capital plan anticipated that over 100 primary care centres would be provided in partnership with the private sector and it is understood that the HSE expected to have approved leases in respect of 40 primary care centres by the end of 2008. [TEXT WITHHELD – SECTION 20 & SECTION 21]

Appendix 1

Rationalisation proposals for Health Sector announced in Budget 2009

- Subsume the National Council on Ageing and Older People into the Office of Older People in the Department of Health and Children.

- Subsume the Children Acts Advisory Board into the Office of the Minister for Children in the Department of Health and Children.

- Subsume the Women's Health Council into the Department of Health and Children.

- Merge the following bodies into the Health Service Executive (HSE):
  - National Cancer Screening Service
  - National Cancer Registry Board
  - Crisis Pregnancy Agency
  - Drug Treatment Centre.

- Subsume the following bodies into the Health and Social Care Professionals Council:
  - National Social Work Qualifications Board
  - Pre-Hospital Emergency Care Council
  - Opticians Board.

- Merge the Postgraduate Medical and Dental Board into, as appropriate, the Dental Council, the Medical Council and the HSE.

- Merge the National Council for the Professional Development of Nursing and Midwifery into, as appropriate, the HSE and An Bord Altranais.

Amalgamate the Food Safety Association of Ireland, the Office of Tobacco Control and the Irish Medicines Board into a Public Health and Medicines Safety Authority.

Health and Children		2008 Estimate	Staff ceiling 2008
Adoption Board *		1,600,000	-
Bord Altranais – Nursing Board			39
Children's Act Advisory Board (formerly SRSB)		2,359,000	22
Crisis Pregnancy Agency		8,959,000	15
Dental Council			4
Drug Treatment Centre **			-
Food Safety Authority of Ireland		18,642,000	84
Food Safety Promotion Board (Safefood)		7,000,000	30
Health Information and Quality Authority		16,840,000	280
Health Insurance Authority			7
Health Research Board		37,375,000	42
Hepatitus C Comp. Tribunal			5
Institute of Public Health		1,608,000	
Irish Medicines Board		5,093,000	259.5
Medical Council			39
Mental Health Commission		21,026,000	26.8
National Cancer Registry Board		3,514,000	28
National Cancer Screening Service		51,320,000	109
National Council for the Professional Development of Nursing and Midwifery		4,579,000	12
National Council on Ageing and Older People		1,819,000	17
National Social Work Qualifications Board		589,000	6
National Treatment Purchase Fund		100,374,000	14
Office of Tobacco Control		2,483,000	14
Opticians Board			2
Pharmaceutical Society of Ireland			14
Pre-Hospital Emergency Care Council		3,519,000	10
Women’s Health Council		673,000	7
	Total	289,372,000	1,086

* 35 staff included in Department of Health & Children numbers
** 110 staff included in HSE numbers for Drug Treatment Centre

Appendix 2

List of policy/Strategy/ Service Review Documents of which the Department of Finance is aware

Department of Health & Children Reports

Description:	Produced by:	Date or date due
Adoption proposals	Internal	2005
Nursing for public health	Joint with NI	2005
Obesity - the policy challenges	Partnership	2005
Action Plan Progress Report (health reform)	Internal	2005
Report of Working Group to nursing staff levels	Internal	2005
Review of Health promotion Strategy	UCG	2005
Review of governance GMS scheme	Deloitte	2005
A strategy for cancer control	Joint	2006
Core functions of the health service report	Internal	2006
Disability Act 2005 sectoral plan for DoHC	Internal	2006
Medical Education in Ireland - Fottrell Report	External	2006
Medical Education in Ireland - Buttimer Report	External	2006
Action Plan Progress Report (health reform)	Internal	2006
Sexual Assault Treatment Services - national review	Joint	2006
Report of the Expert Group on mental health policy	Joint	2006
First report- monitoring Group on mental health policy	Joint	2007
Private Medical Insurance in Ireland	Barrington group	2007
Review of the operations of the Mental Health Act 2001	Internal	2007
Second report- monitoring Group on mental health policy	Joint	2007
Long Term Care Report	Joint	2007
Equal opportunities childcare programme review	Joint	2007

Summary	Totals	
Total reports or prospective reports:	20	
Produced externally:	6	30%
Produced internally:	6	30%
Produced jointly:	8	40%

HSE Reports

Description:	Produced by:	Date or date due
Review of acute hospital services in HSE south	Horwath&Teamwork	2009
Review of acute hospital services in mid west	Horwath&Teamwork	2008
Review of maternity and gyno services for greater Dublin area	Horwath&Teamwork	2008
National Audit of SHO and Registrar Posts	KPMG	2008
An integrated Health system-less acute dependency	External audit group	2007
PA Acute Hospital Bed Capacity Review 2008	PA	2007
Tribal Secta A&E Mapping & Efficiency Review	PA	2008
Emergency Department Task Force Report	Tribal Secta	2008
Acute Hospital Bed Use Review	Various	2007
Improving Health and Achieving Better Standards in NE Region	PA	2007
Review of neurological services	Teamwork	2006
Consultant Staffing 2005	External	2005
National Children's Hospital	Internal	2005
National Children's Hospital	McKinsey	2006
Framework brief for National Children's Hospital	Joint with DOHC	2006
NE regional hospital location study	Internal	2007
Recommendation on location of NE regional hospital	Teamwork	2006
Review of Patient Transport	Various external	2008
Reviews of configuration of adult acute services in Dublin&Midlands	Det Norske Veritas	2009
Review of paediatric services and configuration outside Dublin	Internal	To be agreed
Review of paediatric neurosurgery	Internal	To be agreed
Review of adult critical care services	Horwath/matrix	2009
Review of paediatric critical care	Prospectus	2009
Review of radiology services throughout country	Det Norske Veritas	2009
Review of Child and Family Services-4 region studies	Not yet appointed	2009
National Plan for Pandemic Flu	Internal	2005
Medical Education, training and Research HSE strategy	Joint with DOHC	2007
Implementation plan for the integration of education and training	Internal	2007
Review of Research Ethics Committees and Processes	Internal	2007
Palliative care for non cancer sufferers	Joint with IHA	2008

Summary	Totals	
Total reports or prospective reports:	30	
Produced /to be produced externally:	21	70%
Produced internally:	7	23%
Produced jointly:	2	7%