An Roinn Caiteachais Phoiblí agus Athchóirithe
Department of Public Expenditure and Reform

Budget 2019

Hospital Income – 2013-2017

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HEALTH VOTE

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Summary

- Hospital spend can be broken down into two key components:
    1. Exchequer funding (Net Spend) – this makes up c. 85% gross hospital funding
    2. Own resource (revenue) income – this covers the remaining 15% of gross hospital funding.
- Own resource income grew faster than Exchequer funding over the period 2013-2017. During this time gross hospital spend increased by almost €1bn (21%), broken down as below:
    - Exchequer funded spend grew by €800m (20%)
    - Own resource income grew by €185m (28%).
- Private patient charges and other non-patient income constitute 90% of total receipts in 2017.
- Between 2013 and 2016, private patient income grew by 35%. This is primarily due to the amendment to the Health Act in 2013 which provided for the charging of all private in-patients from 1 January 2014.
- However, since 2016 private patient income has been falling. In 2017 private patient income was 9% lower than 2016 and trends observed to date in 2018 show that this is continuing.
- This decline in private patient income is attributable to a campaign by Private Health Insurers requesting people to opt out of using their insurance if treated in a public hospital.
- Aside from private patient income, hospitals also collect statutory charges from inpatients and outpatients. This other patient income has fallen by 33% between 2013 and 2017, from €99m to €66m. The largest portion of this fall is attributed to a 44% fall in inpatient income which coincides with the increase in private patient income over the period.
- Other non-patient income includes rental income, carpark income, shop and other sales, and internal drug reimbursements.
- Between 2013 and 2017 other non-patient income increased by almost 150% from €74m to €185m. This is largely due to drug reimbursements realised over the period 2016-2017.
- Income budgets appear to be overestimated. This was particularly notable in 2017 when the income budget was almost 10% higher than the actual income raised in the previous year. The budgeting of income would appear to take little account of actual trends.
- Overestimation of income budgets has significant implications for Health spending. This is due to the fact that service levels are committed to on the basis of gross spend not net spend. In the event that the forecasted own resource income levels are not realised, there is a risk that services cannot be delivered unless the Exchequer funds the shortfall.

1. Introduction

In 2017, the Acute sector spent €5.6bn. This spend comprises two elements; Exchequer funding (net spend) and own resource (revenue) income. Since 2013, Exchequer funding made up on average 85% of gross hospital spend with the remaining 15% coming from own resource income.

To date, much of the analysis on hospital spending has focused on the net element i.e. the portion funded by the Exchequer. From 2013 to 2017 Exchequer funding grew by 20% from €3.9bn to €4.7bn while hospital income grew by 28% from €670m to €850m. Given the significant growth in own resource income in just 4 years, it is important to understand what hospital income is made up of and examine what is happening with regard to the trends observed.

Hospital income is made up of a number of receipts including; superannuation, payroll deductions, maintenance charges, inpatient/outpatient charges, long-stay charges, agency services and other receipts. This paper will examine the trends in hospital income from 2013 to 2017 excluding Superannuation. This is due to the fact that an accounting change recently implemented has moved the Superannuation line to a different service line.

This paper will also look at budget management and forecasting of income levels. Typically described as an area outside the control of the HSE, this paper will argue that budget management and forecasting has been a persistent problem since 2013 with year on year over-estimations of income. This has significant adverse implications for hospital expenditure as the income forecast is built into the estimates at Budget time.

The objectives of this paper are to:

- Identify the components of hospital spend and the trend since 2013
- Examine historic income trends and underlying drivers of growth
- Compare actual income outcomes against budget targets
- Identify key risks and challenges facing hospitals with regard to income collection.

2. Hospital Spend 2013-2017

Hospital spend can be broken down into two key components: (1) Exchequer funding (Net Spend) and (2) own resource (revenue) income. On average Exchequer funding makes up 85% of gross hospital funding with the remaining 15% coming from own resource income.

Between 2013 and 2017 gross hospital spend increased by almost €1bn or 21%. This is an average increase of over 5% p.a. When we look at the breakdown of this, it can be seen that of this amount, €800m of the increase was through increased Exchequer funding while €185m was driven by income growth. Proportionately, then, own resource income grew faster than Exchequer funding over the period.

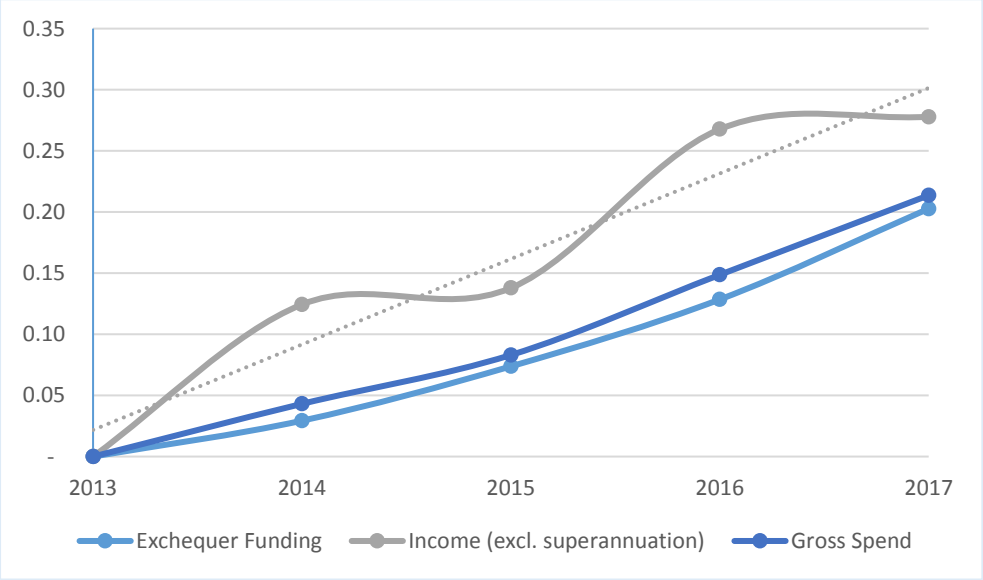
Table 1: Acute Sector Funding Components, 2013-2017

	2013	2014	2015	2016	2017	*2013-2017*	
Exchequer Funding (Net Spend)	3,935	4,051	4,226	4,441	4,733	*798*	*20%*
Income (excl. superannuation)	667	750	759	845	852	*185*	*28%*
Gross Spend	4,602	4,801	4,984	5,286	5,585	*983*	*21%*
Exchequer funding as % Gross spend	*86%*	*84%*	*85%*	*84%*	*85%*		

Source: HSE Management Data Reports, 2013-2017

Figure 1 below shows the growth rate for each of the components of spend. It is clear that income grew at a more significant rate than net spend over the four year period, albeit with more fluctuation.

Figure 1: Component Growth Rate, 2013-2017



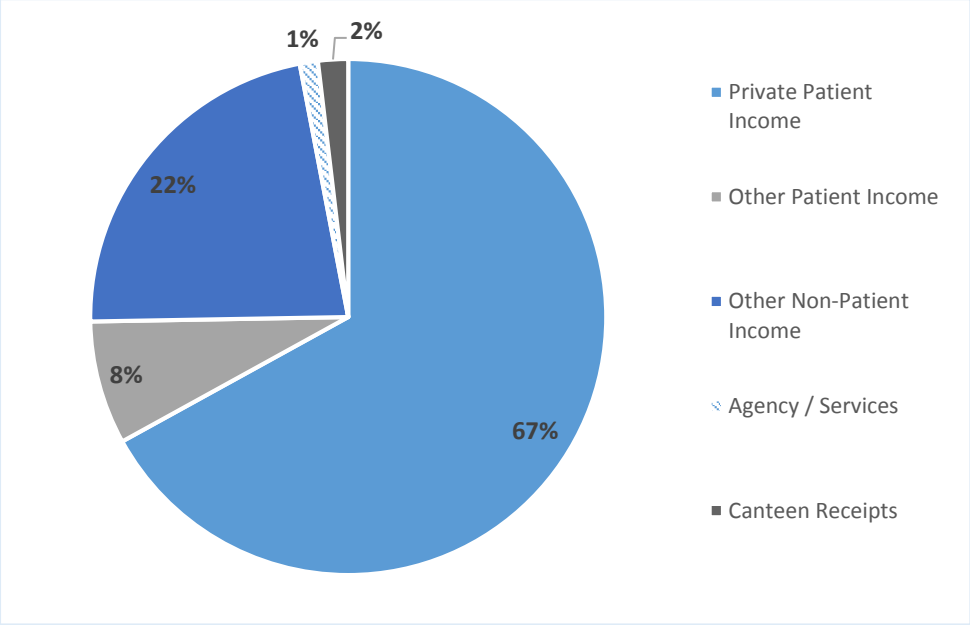
Source: HSE Management Data Reports, 2013-2017

3. Hospital Income 2013-2017

Hospital Income Composition

Hospital income is made up of a wide range of receipts including superannuation, other payroll deductions, patient charges, and other income. For the purpose of this paper, superannuation receipts are excluded from the analysis. This is due to the accounting change which took place in 2016 whereby superannuation was taken out of the Acute services line and included in the overall superannuation provision. The chart below shows the breakdown of receipts for 2017.

Figure 2: Hospital Income Composition, 2017



Source: HSE Management Data Reports, 2017

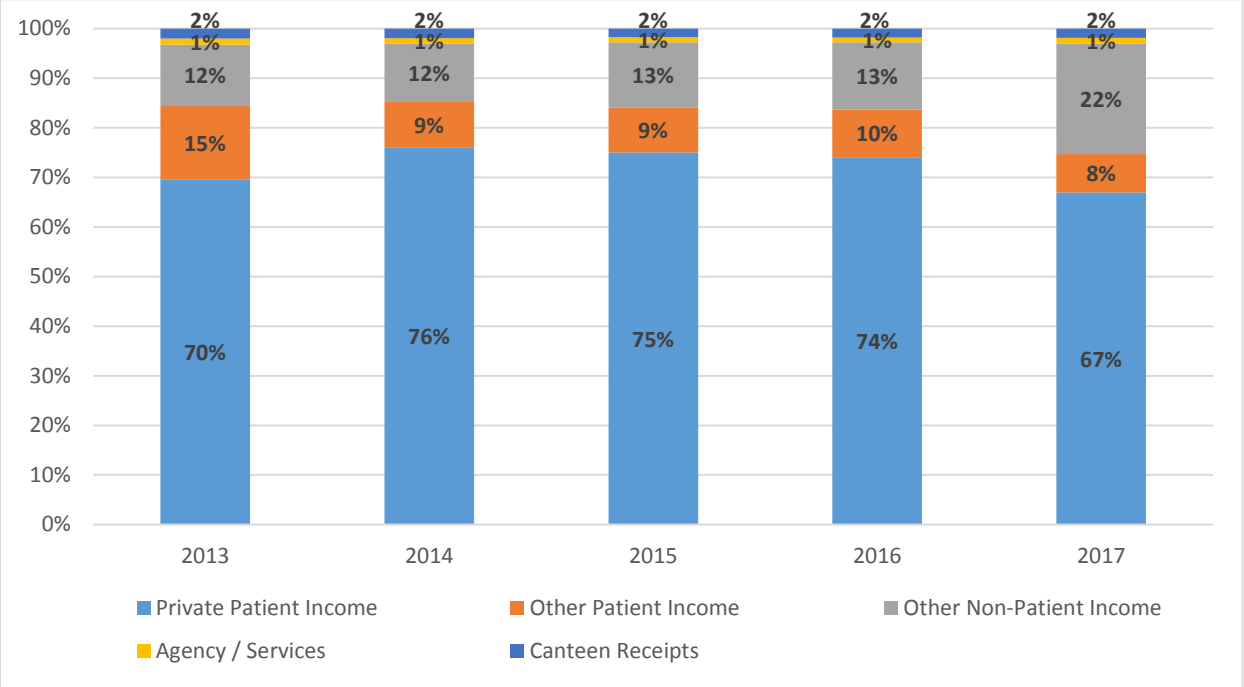
Private patient and other non-patient income constitutes 90% of total receipts in 2017. Other non-patient income comprises a range of receipts including car park receipts, rental income and shop sales. However the largest driver of this category is internal drug reimbursements.

Other patient income represents 8% of total income. This category includes in-patient (IP) and outpatient (OP) statutory charges including emergency department charges. In-patient and outpatient statutory charges represent 5% of total income. The remaining 3% is made up of long-stay patient charges, road traffic accident charges and other charges.

Since 2013, there has been a change in the composition of receipts. Figure 3 shows how in 2013, private patient income represented 70% of total income. This peaked in 2014 at 76%. Since then private patient income has fallen to 67% by end-2017. Over the period other patient income has fallen

from 15% in 2013 to 8% in 2017. Other non-patient income has increased substantially over the period from 12% in 2013 to 22% by 2017. These areas are considered in more detail in the next sections.

Figure 3: Change in Hospital Income Composition, 2013-2017



Source: HSE Management Data Reports

However, despite the changing composition of receipts, income has continued to increase for hospitals over a range of areas.

Table 2: Breakdown of Hospital Income by Category, 2013-2017

	Private Patient Charges (€m)	Other Non-Patient Income (€m)	IP & OP Patient Charges (€m)	Other Patient Charges (€m)	Agency / Services (€m)	Canteen Receipts (€m)	Total
2013	464	82	63	36	8	13	667
2014	570	88	34	35	8	14	750
2015	568	102	33	34	8	13	759
2016	626	114	38	43	8	15	845
2017	571	190	44	21	10	16	852
Change 2013-2017	23%	132%	-30%	-40%	16%	21%	28%

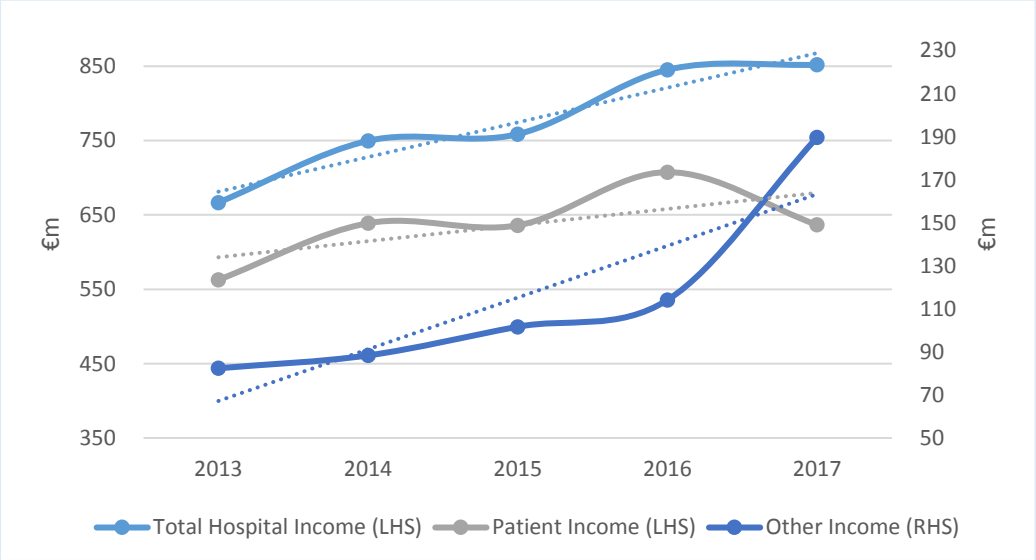
Source: HSE Management Data Reports

Hospital Income Historic Trend

Between 2013 and 2017 hospital income increased by 28% or €185m. This was driven predominantly by growth in private-patient income and other non-patient income. Figure 4 below shows the trend in total hospital income, patient and other income from 2013-2017. The graph shows a drop in patient

income for 2017. This drop is primarily the result of a significant reduction in private patient income which fell by 9% (€55m) between 2016 and 2017. This is discussed in more detail in the next section. However this was offset by a 66% increase (€75m) in other income so that total income actually increased by 1% between 2016 and 2017.

Figure 4: Hospital Income Trend, 2013-2017



Source: HSE Management Data Reports

Data for January – June 2018 shows that hospital income is 9% lower than for the same period last year. The table below shows 2018 performance to date against the same period previous years.

Table 3: Jan-June Performance, 2013-2018

	2013	2014	2015	2016	2017	2018	2013-2018
Total (€m)	332	352	391	420	449	411	79
YoY variance (%)		*6%*	*11%*	*8%*	*7%*	*-9%*	*24%*
Patient (€m)	284	304	336	357	331	300	16
YoY variance (%)		*7%*	*10%*	*6%*	*-7%*	*-9%*	*6%*
Other (€m)	48	48	55	63	118	111	63
YoY variance (%)		*-2%*	*16%*	*15%*	*87%*	*-6%*	*130%*

The data shows that while total income levels in the first six months of 2018 are 24% higher than 2013, they have fallen 9% against the same period in 2017. Patient income is down 9% between 2017 and

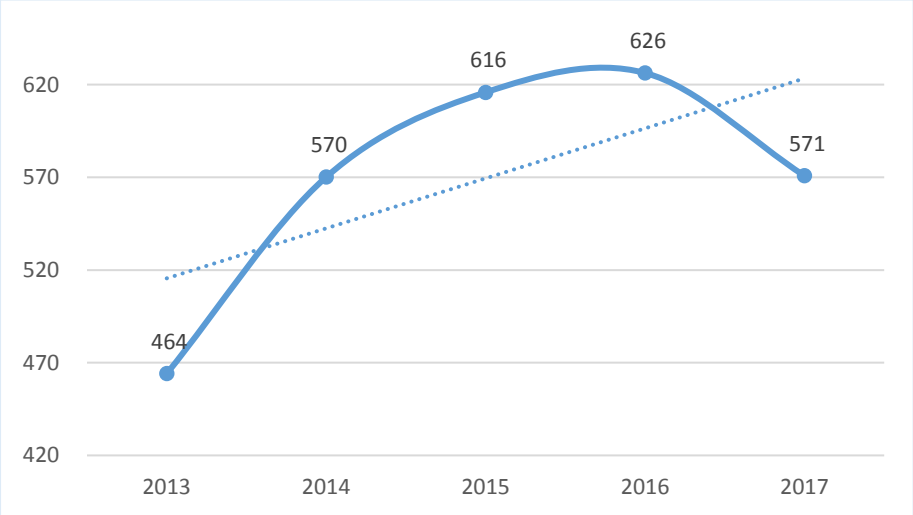
2018 despite being 6% up on the 2013 position. It also reflects a fall of 16% since the peak in 2016. Other income has jumped dramatically since 2013, by 130%, but this growth appears to have slowed with the 2018 position down 6% on 2017. Overall, the trend is worrying and raises questions regarding the HSEs ability to monitor and manage income collection.

Private Patient Income

About 20% of public hospital occupancy relates to "private" activity. Between 2013 and 2017, private patient income increased by €107m or 23%. The largest jump in private patient income occurred between 2013 and 2014. This followed the introduction of legislation in 2013 which provided that hospitals could charge all private in-patients from 1 January 2014. Prior to this, private patients were invoiced for the inpatient charge and the private patient charge (both paid by insurer).

In 2016 private patient income peaked at €626m, however by end 2017 this was back to €570m (a decrease of 9%) and back in line with 2014 levels.

Figure 3: Private Patient Income, 2013-2017



Source: HSE Management Data Reports

However, the 2018 data for January to June shows that private patient income is now €33m (11%) behind where it was during the same period in 2017. The average monthly private patient income in the first half of 2017 was €49.8m, for the second half of the year this average had dropped by 9% to €45.4m. This downward trend shows signs of continuing, albeit at a slower pace, with the average monthly private patient income down to €44.3m in the first six months of 2018. This drop in private patient income is the result of a campaign by Private Health Insurers requesting people to opt out of using their insurance while in a public hospital. Given the proportion of total income that private

patient charges constitute, this represents a significant challenge to Acute income and must be managed accordingly.

Other Patient Income

Aside from private patient income, hospitals also collect statutory charges from inpatients and outpatients. Medical card holders and certain other groups do not have to pay hospital charges. There are several types of hospital charges, including:

- *Out-patient and Emergency Department charges* – if attending the outpatient or ED of a hospital without a referral from a GP, an individual will be charged a standard fee of €100. With a GP referral there is no charge.
- *Daily in-patient charges* – an inpatient is referred to as an overnight stay as a public patient in a public hospital. The standard inpatient fee is €80 per night.
- *Long-term stay charges* – long-stay patients are subject to a maximum fee of €175 per week.
- *Road Traffic Accident (RTA) charges* - Patients receiving hospital care following a road traffic accident (RTA) must pay additional charges for their hospital care.

Table 4: Other Patient Income, 2013-2017

	Inpatient	Outpatient	RTA	Long Stay	Other Patient charges	Total
2013	49	14	11	12	12	99
2014	20	14	9	12	14	69
2015	21	16	7	11	19	74
2016	22	16	7	12	24	81
2017	27	17	9	11	1	66
2013-2017	-44%	22%	-21%	-8%	-89%	-33%
2014-2017	39%	19%	-2%	-7%	-90%	-4%

Between 2013 and 2017, other patient income fell by 33%. All areas fell during this period apart from Outpatients. Since 2014 total other patient charges have dropped by 4%. This is despite increasing numbers attending Emergency Departments and increases in day case numbers over the period[1]. The key area which has significantly reduced since 2013 is inpatient charges.[2]

[1] Lawless, J. 2018. *"Analysis of Hospital Inputs and Outputs, 2014-2017".*

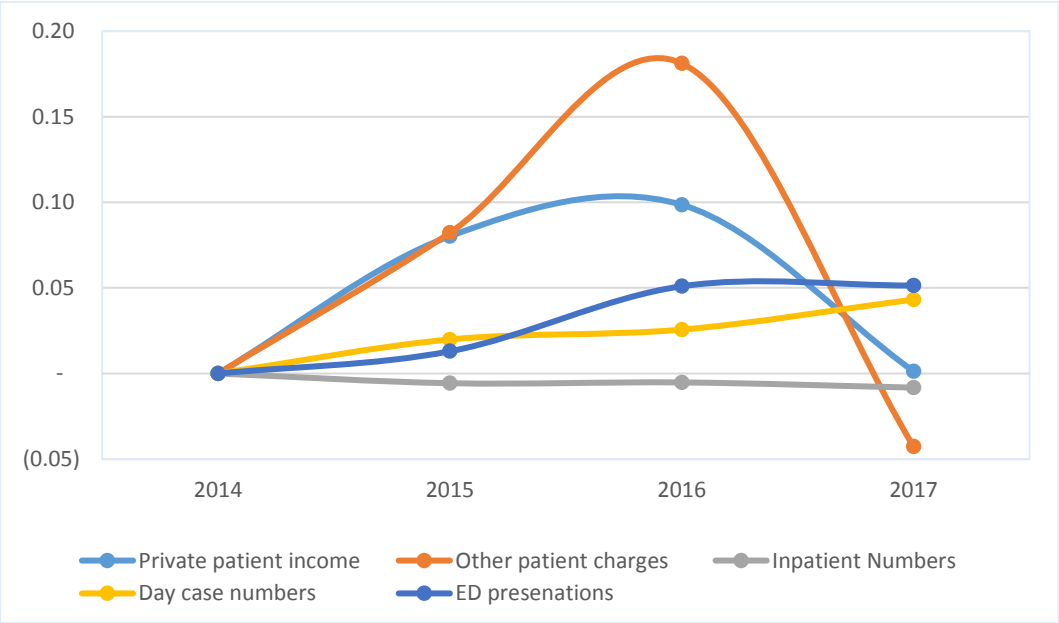
[2]The table also highlights a notable drop of 90% in "Other Patient Charges". This is attributable to an accounting error. In 2016 it came to light that there was an inconsistency in the coding of drug reimbursement income across the hospital system. In 2016 approximately €23m was attributed to Other Patient Charges which should have been covered in drug reimbursements. In 2017 this error was identified and corrected.

The fall in inpatient charges coincides with the amendment to the Health Act in 2013 to provide for the charging by hospitals of all private inpatients irrespective of the type of accommodation used (i.e. previously these patients could only be charged if accommodated in a private bed). The drop in inpatient charges between 2013 and 2014 therefore reflects the increase in charging for private patients via private patient charges which previously could not be charged on a public bed[3].

Subsequently, it can be seen that inpatient income is starting to increase again as the PHI campaign reduces the level of private patient income. Between 2016 and 2017 inpatient income increased by 23%.

The graph below compares the growth rates in private and other patient income against the growth in the number of inpatients, day cases and Emergency Department presentations over the period.

Figure 4: Growth in Patient Charges V. Growth in Patient Numbers, 2014-2017



Source: HSE Management Data Reports

The graph shows that between 2014 and 2016, private patient income and other patient charges grew by over 10%. This performance was significantly higher than the growth observed in patient numbers observed over the period. However, between 2016 and 2017 this trend reversed dramatically with both private and other patient charges falling despite continued (albeit modest) growth in Emergency Department and day case presentations. With regard to other non-private patient income, this trend

[3] Post the legislation there was just one private patient charge which incorporated the previous in-patient charge. Patients were therefore only invoiced for maintenance charges. As a result a portion of the drop in in-patient income was really a reclassification from inpatient to maintenance due to the way the charges were now being billed.

is concerning and one that requires careful analysis and monitoring to understand the drivers of this reduction.

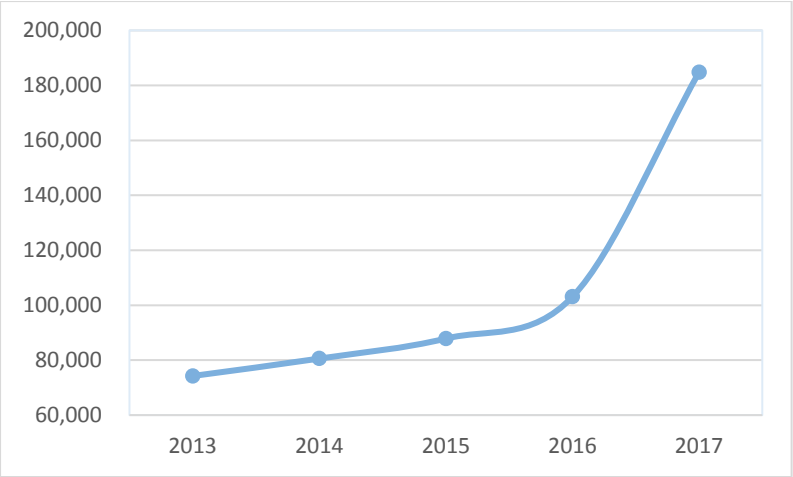
Other Non-Patient Income

Other non-patient income comprises a number of components including rental income, carpark income, shop and other sales, and internal drug reimbursements. Part of the drop in private patient income has been offset against increases in other non-patient income. Between 2013 and 2017 this income line increased by almost 150%.

Internal drug reimbursements represent the biggest component of this income and has grown significantly over the period 2013 to 2017. The largest jump observed in 2016/17 is primarily due to an accounting error that came to light in 2016. It was discovered that there was an inconsistency in the coding of drug reimbursement income across the hospital system. In 2017 all hospitals were instructed to budget and charge internal drug reimbursement income to 'Other Income', this resulted in a growth in this income line and reductions or smaller growth than in previous years for other income budget types.

Crucially, however, this level of increase in other non-patient income is not sustainable over the long term and cannot adequately compensate for the drop off in private patient income. This is because it is largely comprised of drug reimbursement income which represents an internal funds transfer. It is not revenue generating in its nature. In other words, drug reimbursement income is only generated on the back of the Exchequer funded purchase of drugs.

Figure 5: "Other" Non-Patient Income

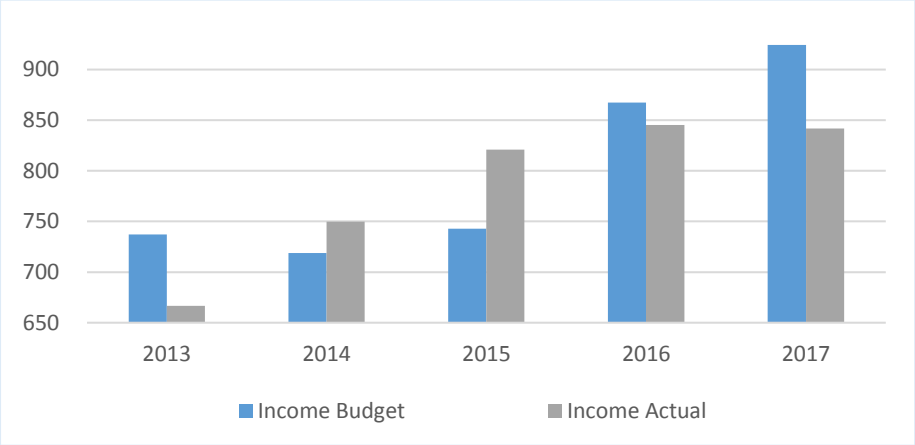


Source: HSE Management Data Reports

4. Hospital Income Budget Management

Hospital Income budgets have been increasing since 2014. The graph below shows actual income against budget for 2013 to 2017. There is a notable upward shift in the budget growth 2013-15 and 2015-17 which is not reflected in the actual income collected for these years. The graph shows that between 2013/15, income budgets grew by just 1% while actual income grew by 23%. Conversely, between 2015/17, income budgets grew by 24% while actual income grew by just 4%.

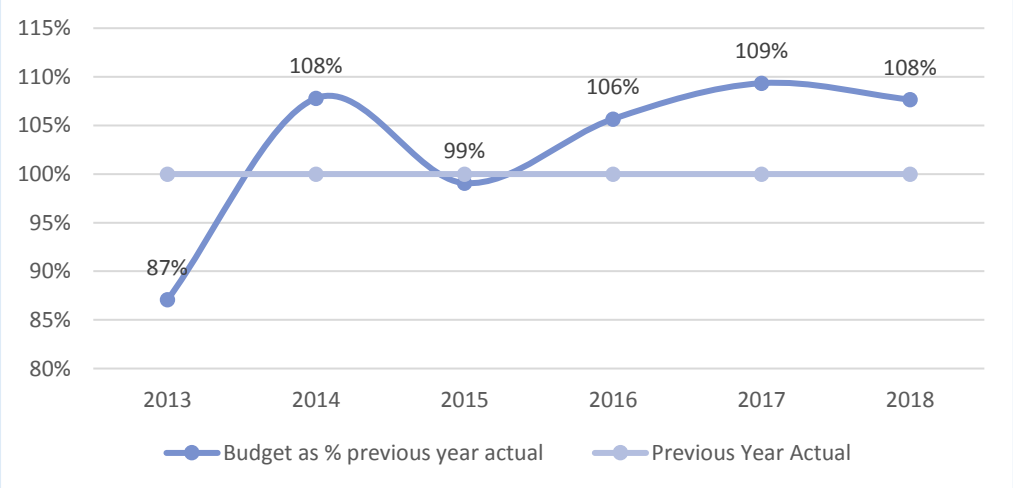
Figure 6: Hospital Income Budget v. Actual, 2013-2017



Source: HSE Management Data Reports

It would, therefore, appear that hospital income budgets take little account of the previous year's actual performance. In 2013 the budgeted income level was 13% lower than the actual income generated in 2012. For 2014, 2017, and 2018 income budgets were set almost 10% above the previous year's income level. This in demonstrated in Figure 6 below:

Figure 7: Budget as % Previous Year Income



Source: HSE Management Data Reports

This overestimation of income budgets, particularly of the magnitude observed in the last two years, has significant implications for Health spending. This is due to the fact that service levels are committed to on the basis of gross spend not net spend. In the event that the forecasted own resource income levels are not realised, there is a risk that services cannot be delivered unless the Exchequer funds the shortfall.

Conclusion

Health spending is a function of Exchequer funding and own resource income generation. Between 2013 and 2017, gross Health spend increased by almost €1bn (21%) between 2013 and 2017. This growth was driven by a 20% (€800m) increase in Exchequer funding and a 28% (€185m) increase in income generation.

While income levels have been growing it is clear that the growth has not been consistent across all areas and there are concerns regarding the sustainability of the growth observed in other areas.

Private patient income represents 67% of total hospital income. Between 2013 and 2016, private patient income grew continuously. However, this trend reversed in 2017 when private patient income fell by 9%. This is due to a recent campaign by private health insurers requesting people to opt out of using their insurance unless being treated in a private hospital bed. This drop in private patient income was offset by significant growth in "other" non-patient income. Other non-patient income grew by 150% between 2013 and 2017. This is largely attributable to drug reimbursements realised following the implementation of the IPHA agreement. However, the sustainability of this growth in other income is questionable due to the fact that the drug reimbursement funding is an internal transfer of funding and not revenue generating in nature. While private patient and other non-patient income represent the key components of total hospital income, other patient income has fallen back to 2014 levels in the last year. It is unclear what is driving this reduction as patient numbers have increased modestly over the period.

A key issue emerging from the analysis of hospital incomes is that of management and forecasting. With regard to income budgets and forecasting, overestimation of income budgets has been a recent trend in the Acute sector. This has significant implications for Health spending due to the fact that service levels are committed to on the basis of gross spend not net spend. In the event that the forecasted own resource income levels are not realised, there is a risk that services cannot be delivered unless the Exchequer funds the shortfall.

There is an obvious challenge presented in the area of Hospital income and, to date, it is not clear what steps are being taken to address this. In the absence of careful budget management and credible assumptions underpinning the annual forecasts, there is a risk that the integrity of the annual Health budget is undermined.

Quality Assurance

Quality assurance process

To ensure accuracy and methodological rigour, the author engaged in the following quality assurance process.

✓ Internal/Departmental

✓Line management

✓ External

✓ Other Department