Joint Committee on Health Meeting
Wednesday 13th December 2017

Opening Statement of the IMO

The IMO on behalf of Doctors in Ireland would like to thank the Chairman of the Joint Committee on Health, Dr. Michael Harty TD, for inviting the Irish Medical Organisation to a meeting with the Committee following on from the Prime Time programme which aired on the 21st November 2017 on RTE.

We understand that in particular the Committee wishes to discuss oversight and monitoring of Hospital Consultant Contracts including enforcement, impact on waiting lists, 'stretch income targets' and issues relating to the role of clinical directors and hospital management.

We are happy to engage with the Committee on the content of that particular programme. However, at the outset, it is important that we advise the Committee that, as you will be aware litigation is currently before the Courts in relation to the failure by the Government and the HSE to implement contractual pay increases to consultants. Having taken legal advice on the matter we will be unable to comment on the issues or matters before the Courts.

In relation to the issues which the Committee wishes to discuss we would highlight the following:-

The Committee will be very much aware that there is no single uniform Consultant Contract. Currently, there are seven clinical Consultant contracts held by active working Consultants. The earlier arrangements dating from 1991 and 1997 respectively are still held by several hundred Consultants and allow those Consultants to engage in off-site private practice with limits determined by the type of contract held.

For instance, a Category I contract from 1997 entitles the holder to engage in limited outpatient private practice, while the Category II

contract would entitle the holder to engage in a greater scope of private practice in for example, private rooms, clinics or hospitals. Both contract types do require the employer to be satisfied that the Consultant's public commitment is also being fulfilled.

In both cases, the ratio of private to public beds can determine some aspects to the Consultant's access to private practice.

However, over eighty percent of Consultants now hold a 2008 Contract. The Committee will be aware that the 2008 contract was, firstly several years in the negotiating but also was predicated on Co-located hospitals allowing Consultants to provide care to patients in a co-located private Hospital on public hospital campuses. With some small number of exceptions, these facilities have not materialized, and that has presented a significant challenge for capacity in the public hospital system.

The contract types offered in 2008 – A, B, B* and C – allowed for up to thirty percent of a Consultants time to be set aside for private practice depending on the contract that the Consultant signed, which in turn may have depended on the type of contract held by a Consultant prior to signing the 2008 contract.

The most commonly held contract is the 2008 Type B contract which is held by over half of Consultants. If a Consultant who currently holds a Type B contract held a contract prior to signing the Type B contract in 2008, that Consultant will have the right to off-site private practice, and may also spend up to thirty percent of their time engaged in private practice in facilities operated by the employer. If the Consultant, who now has a Type B contract, did not hold a contract prior to 2008, they have a right to devote twenty percent of their time to private practice in facilities operated by the employer.

It is worth noting too that if an employer cannot provide a Type B Consultant with facilities on the hospital campus for outpatient private practice "the Employer shall make provision for such facilities off-campus, on an interim basis, pending provision of on-campus facilities."

In many cases, such on site facilities were not forthcoming.

As you can see, the contractual landscape against which Consultants operate is a complicated one.

The position of the IMO is clear; Contracts must be upheld. The Prime Time Investigates Programme presented several extreme examples of alleged non-compliance with contractual obligations and suggested that this was representative of the practices of "a significant minority" of Consultants. It is worth remembering that there are approximately three thousand Consultants in the system, suggesting that the apparent actions of a very small number of Consultants is in anyway representative of the group, as a whole, is simply not tenable.

While we cannot comment on individual, clearly extreme, cases, particularly without having full possession of the facts, we are concerned that these examples would be used to tar all Consultants with the same brush.

Indeed we do note that both the Minister and the HSE, in responding to the Programme, accepted that the majority, the overwhelming majority, of Consultants worked beyond their contractual commitment.

Furthermore, in a survey of members, we found that Consultants are working up to twenty hours a week in excess of their contractual commitment - that is the lived reality of delivering specialist medical services in Ireland.

In respect of the mix of public and private patients in our hospitals, while Consultants have limited determination over who is admitted, we would point out that the Department of Health's own report on Trends in Public and Private Activity in Public Acute Hospitals found that public patients accounted for approximately 83% of hospital discharges over the period 2012 to 2016.

With regard to the suggestion / accusation that Consultants mix of public and private patients has become skewed in favour of the

private, the reality is that patients holding Private Insurance, as citizens of this State, are entitled to access care in public or private hospitals, and their decision to access care privately means that procedures that the public hospital system would have to provide and pay for otherwise, are performed in private institutions.

The National Treatment Purchase Fund is daily evidence that not only does the Government know that public hospitals are unable to provide timely care, but that it is willing to use public funds to pay the private sector to provide care that should be available in public hospitals, but is not, due to inadequate resourcing of the acute hospital system in Ireland.

This under resourcing, which is the default position of the Government, results in ward bed closures, closed operating theatres, cancelled planned admissions and delayed emergency admissions, with the resultant patient hardship and staff being frustrated in their efforts to deliver timely optimal care.

With respect to Hospital management and oversight of Consultant contracts, the private patient numbers allowed by holders of the type B and type C is between 20 and 30 % depending on the time the contract was taken up.

It is harder to identify what limits are placed on Consultants holding the 1997 contract and older contracts.

Hospital management have, within the 2008 Consultant contract, the ability to first notify a Consultant if his or her private practice ratios are in breach of the public: private ratios set out in their contract, and to advise that these ratios must be met within six or nine months.

However, hospital management are in the invidious position of simultaneously having to advise Consultants if they exceed their allowed private public ratio, whist at the same time needing to maximize funding for the hospital received from private patients and their insurers.

Each year, the HSE sets each hospital a target for private practice income to be generated. The HSE's very own Service Plan for 2016 requires that acute hospitals private income receipts vary from the planned target by no more than 5%. Approval was given by the HSE, and the Minister, to promote the generation and collection of private charges income.

Let us be clear, the inconvenient truth is that private practice in public hospitals helps to pay for the delivery of care to public patients. Yet again due to the lack of capacity in the acute hospital system it is not uncommon for a public patient to be in a designated private bed due to clinical need which has income loss implications for the public hospital and in turn implications for funding of care in the hospital.

In excess of 44% of the population of Ireland hold private health insurance and as such can opt to be treated as a private patient in hospital. Consultants cannot deny a patient an emergency admission to hospital because they hold private insurance and so their ability to control their public private mix is challenged by the number of patients they admit on call as emergencies who elect to use their private health insurance for that admission. Typically Consultants are unaware, and rightly so, that a patient under their care as an emergency admission is a private patient until such time as they are made aware of this by Hospital management so that the Hospital can then bill the patient's insurer for their hospital stay and generate much needed funds.

I'd like to say a few words on the position of Clinical Director; the role of the Clinical Director is set out in the 2008 contract and is a role aimed at increasing the involvement of senior clinicians in hospital management. It is through the directorate structure that the individual Consultant liaises with senior management and vice versa. This role is meant to be supported by a business manager for each directorate as well as a director of Nursing. It is, in many hospitals, an under resourced role both in terms of time allocated to the performance of the duties and support structures put in place for the Clinical Directors.

At present, we in the public health service are experiencing a recruitment crisis when it comes to Consultants. We simply don't have enough Consultants, and we are struggling to recruit new highly trained colleagues into Consultant posts. The National Task Force on Medical Staffing from 2003 suggested that we would need 4,400 Consultants to deliver specialist medical care today, however we have just over 3,000 approved Consultant posts, of which 200 are filled on a temporary basis only, and an indeterminate number, approx. 400, are either vacant or otherwise filled on an unclear basis.

We are not recruiting Consultants in sufficient numbers to deliver a specialist medical service or to meet required replacement rates. In 2016, eight advertised Consultant posts received no applicants; a further twenty two posts received just one applicant and twenty one posts received just two applicants. Overall 66 advertised posts received five or fewer applicants.

Most damningly, perhaps, figures produced by the Public Appointments Service, which runs recruitment campaigns on behalf of the HSE, show it was "unable to identify a suitable candidate" for 22 of the 84 posts that were advertised in 2016.

If we propose to have a health service delivered by suitably qualified medical specialists – this cannot be allowed to continue. Using FEMPI legislation and other devices health service management have driven down the pay of Consultants; we are not competitive internationally and the recruitment figures would suggest that we have given up even trying to compete.

Indeed, if Consultants were to claim all of their entitlements as set out in their contracts, with regard to compensatory rest and premium pay, for example, we would see a significant uptick in the cost of delivering health services in this country.

In conclusion, and with all due respect to the makers of the programme, to focus on the alleged actions of a tiny number of unidentified Doctors, is to miss the much larger point.

We do not have sufficient medical specialists to deliver the type of care that is taken for granted by patients in most other comparable countries. What is required is a drive for real investment in the public system that will facilitate Consultants and their teams providing timely care to patients, and that is where our collective energies should be directed.

The IMO has been to the fore in championing a top class fully functioning public health service. However, laying the blame for all of the ills of the service at the door of a small number of Doctors would be to spectacularly miss the point.