

Mr. Michael Scanlan (*Secretary General, Department of Health and Children*) and **Professor Brendan Drumm** (*Chief Executive Officer, Health Service Executive*) called and examined.

Chairman: I draw everyone's attention to the fact that while members of the committee enjoy absolute privilege, the same privilege does not apply to witnesses appearing before it. The committee cannot guarantee any level of privilege to witnesses appearing before it.

Furthermore, I remind members of the long-standing parliamentary practice to the effect that members should not comment on, criticise or make charges against a person outside the House or an official by name or in such a way as to make him or her identifiable. Members are also reminded of the provisions in Standing Order 158 that the committee shall refrain from inquiring into the merits of a policy or policies of the Government or a Minister of the Government or the merits of the objectives of such policies.

I welcome Mr. Michael Scanlan, Secretary General at the Department of Health and Children, and ask him to introduce his officials.

Mr. Michael Scanlan: I am accompanied by Dr. John Devlin, a deputy chief medical officer, Mr. Dermot Smith, Mr. Fergal Lynch, Mr. Fergal Goodman and Mr. Paul Howard.

Professor Brendan Drumm: Thank you, Chairman. With me is Mr. Barry O'Brien, assistant national director of the human resources directorate, Mr. John Hennessy, a national services manager with the integrated services directorate, and Mr. Liam Woods, our national director for finance.

Chairman: Do you have any other officials with you?

Professor Brendan Drumm: Yes, Mr. Andrew Condon, who has been very involved in the management of the consultant contract and Mr. Ray Mitchell, our liaison with the committee.

Chairman: I welcome the officials from the Department of Finance and ask them to introduce themselves

Mr. Tom Heffernan: I am Mr. Tom Heffernan from the sectoral policy division of the Department of Finance.

Chairman: I ask Mr. Buckley to introduce chapters 37 and 39. The full text of the chapters can be found in the annual report of the Comptroller and Auditor General or on the website of the Comptroller and Auditor General at www.audgen.gov.ie.

Mr. John Buckley: The chapters from the annual report of 2008 being considered today deal with two interrelated issues. The chapter on private patient income outlines the circumstances that gave rise to a situation where 50% of private patients accommodated in public hospitals in 2008 who paid their consultants for the treatment element of their care ended up not paying for maintenance costs incurred by the hospital in which they were treated. Of the other 50% who were charged for their accommodation, the maintenance charge did not represent the full

economic cost, and there were delays of an average of six months when collecting the money, the bulk of which comes from insurers. These delays were ascribed to outmoded administrative systems and delays in sign off of insurance claims by consultants.

The health service incurs administrative costs in processing claims on behalf of consultants, even in those cases where no maintenance income is recoverable from the insurers. The underlying causes of the non-collection of maintenance charges can be ascribed to three main factors. One is private patients being accommodated in beds other than those designated for private patients. This is because maintenance charges are only covered by insurers for designated private beds. The second is income being foregone because beds that are designated for private patients are allocated to public patients. Approximately 83,500 public patients were accommodated in designated private beds in 2008. The third is the fact that a proportion of patients who present as private patients end up designated as public patients by virtue of the fact that they are seen or treated by a category A consultant. A total of 37% of consultants fall into that category. While accepting that each of the causes outlined above flows from existing policies, the associated implementation mechanisms do not align or mesh in a way that allows for a workable organisation of the public and private case loads. The State ends up facilitating private medicine without being recompensed for a good proportion of the service it provides in respect of private patients.

Turning to the consultants contract 2008, at the time of my report 89% of consultants had agreed to new forms of contract with 37% of consultants devoting their time exclusively to public patients. The challenge facing the health service is to ensure that the changes envisaged in the new arrangements are implemented on the ground. The increased salary payments, which are instalment based, have begun to be made based on confirmation of formal compliance. This formal compliance was the subject of confirmation by the HSE through ensuring, first, that signed contracts incorporating the revised provisions exist for the consultants who opted into the arrangements and, second, that schedules are in place at hospital level that make allowance for the extra time commitment negotiated. However, when my report was finalised in September 2009 arrangements had not yet been embedded to monitor the extent of private practice in individual cases, to verify the operation of the clinical directorates and to monitor delivery of commitments for consultants on pre-2008 contracts. The risk in instances where the State pays for change in advance of its delivery is that it will not materialise unless there is an active ongoing verification process in place based on a change management plan. The Accounting Officers will be in a position to update the committee in this regard.

Chairman: 🗣️ 🗣️ Thank you, Mr. Buckley. I invite Mr. Scanlan to make his opening statement.

Mr. Michael Scanlan: I am pleased to meet with the committee today to discuss chapters 37 and 39 of the 2008 report of the Comptroller and Auditor General on Vote 40 for the Health Service Executive, dealing with the management of private patient income and implementation of the medical consultants' contract.

I will discuss the medical consultants' contract first. Agreement on a new contract was reached in negotiations in January 2008. It was accepted in IHCA and IMO ballots in May and June 2008, respectively. Final contract documentation, reflecting work done by Mr. Mark

Connaughton, who had chaired and helped us throughout the process, issued to consultants in late July 2008. However, certain difficulties then arose about the number, role, etc. of clinical directors who were seen as having a pivotal role in the implementation of the new contract. It previously had been agreed that consultants who signed the new contract would receive a 5% increase in salary with effect from 14 September 2007 and a further increase, the level of which would depend upon the individual's existing and new contract type. Half of the further increase was to be paid from 1 June 2008 and the balance from 1 June 2009.

Although the Minister sought and received Oireachtas approval for a Supplementary Estimate to cover the 2008 costs of the new contract, it was ultimately decided not to proceed with the new salary rates in the absence of sufficient demonstrable progress in implementation on the ground and, as a result, no payments were made in 2008 in respect of the new contract. That remains the case. In February 2009, following a verification exercise undertaken by the HSE, the Minister decided that she would be prepared to commence payment of the new contract rates. It also had been confirmed by that stage that colonoscopies and endoscopies would be included within the definition of outpatient and ambulatory diagnostic services and, therefore, would be provided on the basis of a common waiting list. However, by that stage, the fiscal situation had deteriorated significantly and severe expenditure pressures had also emerged in the HSE's Vote.

Ultimately, the Minister announced on 24 April 2009, in the context of the supplementary budget, that she was prepared to sanction part payment of the new salary scales for consultants who signed up to the new contract. The previously agreed rates would apply from 1 January, but the final phase due from 1 June 2009 was not sanctioned and the Minister also decided not to sanction increased on-call and call-out payments. It was estimated that this would save approximately €75 million in 2009, along with nearly €70 million not paid in 2008. The Minister has indicated that the deferred increase would be reviewed in September 2010 on the same basis as the deferred increase awarded to ministerial and parliamentary office holders and for other senior public servants under the Review Body on Higher Remuneration in the Public Sector, report 42. However, she also said this is without prejudice to any decisions the Government might make in the interim regarding the remuneration of senior public service grades generally arising from the review, which at that point was about to be undertaken but which has since been completed by the review body. I understand the new contract has been accepted by nearly 90% of consultants and that Professor Drumm will outline for the committee the steps taken to date by the HSE to audit and verify implementation.

Chapter 37 of the Comptroller and Auditor General's 2008 report examines the extent to which private patients are treated in public hospitals, whether all patients who had a private treatment relationship with their consultant are charged for accommodation by hospitals, and whether the full economic cost is being levied. The timeliness of debt recovery by public hospitals is also considered. It is important to reiterate at the outset that all persons ordinarily resident in Ireland have full eligibility for hospital services and that although Irish public hospitals treat private patients, the core purpose of the public system is to provide services for public patients. Government policy has been to ensure there is equitable access for public patients and, accordingly, that the proportion of private activity is appropriately controlled.

Bed designation was introduced as part of the overall framework to control the level of private activity in publicly funded hospitals. Under 1991 regulations, beds in public hospitals are categorised as public, private or non-designated. Under these regulations, no private patient being admitted electively may be accommodated in a designated public bed.

Chairman: I must briefly interrupt Mr. Scanlan. Due to a breakdown in the electronic system here, we do not have an indication of votes in the House. A vote has been called and there will be the usual arrangement of myself and one of the Government Deputies being paired. We will continue with the reduced number of members. I apologise for the interruption.

Mr. Michael Scanlan: The regulations contain reciprocal provisions regarding the accommodation of public patients in beds designated as private. There is provision for some exceptions to cater for emergencies and an instruction has been issued which permits the accommodation of a public patient in a designated private bed where this is necessary to manage health care associated infections.

Chapter 37 draws attention to the impact of the new consultant contract on private patient income and, in particular, the potential implications of the new type A contract. As indicated in the report, the intention is that the private practice provisions in the new contract will provide an additional lever, along with bed designations, to improve access by public patients. The Minister has also made her policy position regarding type A contracts clear, that is, public hospitals may not raise a private accommodation charge where a patient is admitted under the care of a type A consultant, nor may another consultant involved in the treatment of such a patient charge a fee. It is against this background, and within the context of stated Government policy, that the analysis presented in chapter 37, which indicates that 50% of private inpatients in 24 acute hospitals were not charged for their maintenance, must be viewed.

Care is needed to ensure that a perceived need to generate income does not operate to the detriment of service provision to public patients. The primary objective must be to avoid an excessive ratio of private practice within public hospitals and, subject to that being achieved, to recover whatever income is due in respect of that level of private practice.

The public hospital system should, of course, have efficient and effective procedures for collecting income which is due. I understand Professor Drumm will outline for the committee the steps that have been taken by the HSE in this regard. I would also mention that, following a meeting earlier this year between the Minister and the VHI - and as part of a package put in place to enable the HSE to continue to implement its national service plan - it was agreed that the VHI would make a one-off payment on account of €50 million this year towards the outstanding amounts owed to the HSE.

Since the publication of the White Paper on private health insurance in 1999, Government policy has been to move towards charging the full economic costs for the use of public facilities and services for private patients, while being sensitive to the need for continuing stability in the private health insurance market and wider inflation concerns. This policy has seen significant increases in private charges in recent years. For example, a 20% increase was introduced in 2009.

The Department is currently undertaking a value-for-money and policy review of the economic cost of private and semi-private treatment services in public hospitals. This is referenced in the Comptroller and Auditor General's report. The purpose of the review is to carry out a detailed analysis of the costs and charges associated with providing private and semi-private treatment services in public hospitals and investigate the fee collection processes used to recoup the cost of these services from private health insurance companies. Appropriate recommendations will be formulated in each of the areas of cost, charge and fee collection. The review will also examine options in relation to changing the current costing methodology, which is based on an average cost, to an alternative approach which more closely reflects the true economic cost. An interim report is currently being drafted and the final report is expected to be completed in December.

Chairman: Thank you, Mr. Scanlan. May we publish your statement?

Mr. Michael Scanlan: Yes, Chairman.

Chairman: Thank you. I now call on Professor Drumm to make his opening statement.

Professor Brendan Drumm: I would like to start on the collection of costs from health insurers for treating private patients in the first place, and then on the 2008 consultant contract. As regards private patient income, before setting out the specifics in terms of recouping private patient accommodation costs, I would like to highlight a few points. First, we are not yet satisfied with the time it is taking to recover accommodation costs from health insurers for patients treated in HSE and voluntary hospitals. Second, the delays in processing claims create primarily cashflow issues, but do not affect the amount of money eventually recovered by hospitals from insurers. Third, in general, HSE and voluntary hospitals recover 97% of private patient accommodation costs from insurers.

A number of initiatives have been introduced to address this situation and they include the following. A high-level group from the HSE and the voluntary hospitals has been working with health insurers to streamline the claims processes. At the moment each private patient insurance claim essentially has two parts, which is the critical issue. The private accommodation costs are payable to the HSE or voluntary hospital and the cost for providing private clinical services is payable to the consultant or consultants.

Claims for hospital accommodation costs, however, are not accepted by insurers unless they are signed off by the primary consultant, so we cannot collect our money without the consultant having signed off on our bill. This administrative requirement causes major logjams. Ideally, we would like insurers to remove this requirement. This would mean that hospitals would not then be dependent on consultants signing off on claims forms to recover private patient accommodation costs from insurers.

Insurers have now agreed to process claims signed off by a secondary consultant where there has been a significant delay in sign off by the primary consultant. However, there is no doubt that this entire issue would be resolved to a large degree if we did not require consultants to sign off on our fees.

The VHI has also agreed at this stage to introduce an improved payment arrangement. As the Secretary General mentioned, a payment on account of €50 million has been agreed in lieu of payments due. We anticipate receiving this payment shortly. We are exploring the possibility of having similar arrangements with other insurers.

In addition, we are now beginning to centralise the HSE's entire billing system for all billings across the country, which will be based in Kilkenny. This centralised approach will streamline all insurance claims and debt-collection processes.

The most up-to-date position on insurance claims is that there are claims for private accommodation costs of approximately €1 million currently being processed by insurers. This includes claims which are the subject of further information requests from insurance companies amounting to about €1 million. Outstanding claim forms, including private inpatient and day-care accommodation costs, amount to approximately €4 million, which are awaiting sign-off by consultants.

We have now introduced a major drive to have all outstanding claim forms signed off by consultants, submitted and paid by the end of the year. This is a very ambitious undertaking and each hospital has been issued with a target it must meet. Achieving this target will treble our current weekly cost recovery from insurers until the end of the year to over €20 million a week. A major factor determining the ability of hospitals to meet this target will be for consultants to sign off on all insurance claims in a timely fashion. I would encourage the consultants to co-operate fully with their local colleagues in achieving this, as ultimately the collection of this money is critically important to maintaining front-line services. The insurance companies are co-operating with us in this specific endeavour. Hospitals can now submit claims as they are ready, rather than once a month.

Our drive to recoup costs from health insurers this year could result in a decrease in cashflow from this source early next year. To try to address this, next year hospitals will have specific debt recovery targets. Hospitals that fail to reach their target will be subject to budget sanctions. Our target is to recover all outstanding debts within 30 days.

I now wish to deal with the issue of the consultant contract. The consultant contract 2008 introduces reforms which will benefit patients, move towards a consultant-provided service, and maximise the return from taxpayer investment in existing and additional consultant posts. These include the following: a longer working week of 37 instead of 33 scheduled hours; a longer working day, potentially from 8 a.m. to 8 p.m. instead of 9 a.m. to 5 p.m.; greater equity for public patients through a public-only contract type; limits on private practice and a common waiting list in diagnostic services; measures to ensure high quality services and patient safety; and the introduction of clinical directors - which is a huge advance - to manage consultants' clinical work and ensure that clinicians have a senior role in planning and managing services.

Some 1,688, or 90%, of the 1,888 consultants employed by the HSE in August 2008 signed up to the new contract. In addition, we have since created 218 entirely new consultant posts and approved 195 replacement consultant posts under the new contract. Over 400 consultant posts have been put in place since this. This represented a 10% increase in the overall number of

consultant posts when one takes the new posts into account. It means that the new contract applies to 86% of consultants. The figures are that 2,025 of the existing 2,350 consultant posts have now taken the contract.

A unique and significant feature of the new contract is the creation of the post of clinical director. Clinical directors are key members of local corporate management teams. They plan how clinical services are delivered and how resources are employed. They contribute to deploying and managing consultants, strategic planning and achieving local clinical priorities.

Consultants report to their assigned clinical director who monitors and manages the public-private mix of their work where relevant, and develops and manages rosters. The current emphasis is on introducing rosters so that there is on-site consultant cover 12 hours a day, maximising the value of the additional four hours per week from each consultant. Clinical directors also deal with a range of other quality, safety and organisational issues.

In early 2009, a process started to verify that the new contract was being implemented as planned. I note the co-operation we have received from the four postgraduate training bodies for the different specialties in establishing and implementing what I believe is a unique form of clinical directorate in this country. It is one that will be of immense interest to other countries in terms of the success in getting it going.

A key element of the contract is the regulation of each consultant's public and private practice. In September 2008, we introduced new measurement systems to do this. The measurement system has been rolled out to the 49 acute hospitals and captures inpatient and day-case activity carried out by each consultant. This is weighted for case mix, which is extremely important as it gives an indication of the complexity or lack of complexity of the work. It reports on the level of private practice on a monthly basis. Details of on-site private outpatient activity and certain diagnostic activity are being collected manually by hospitals as an interim measure pending the development of an automated data collection system. The agreement and rules under which these measures were collected has been a huge undertaking and has now been agreed by all.

Consultants employed by the public health service, irrespective of whether they are employed under the consultant contract 2008, are now issued with a public-private mix measurement report every month. This documents their activity in regard to inpatient, day case and outpatient activity during the previous three months.

This measurement system is essential and when combined with the performance data we are now collecting through our HealthStat process, we have a very powerful combination to drive change. HealthStat concentrates on the output and throughput of facilities and individual consultants. By comparing data across the system, we can establish where taxpayers' investment is having the greatest impact and can make effective planning decisions based on this data.

The third interim report of the Committee of Public Accounts on the 2006 report of the Comptroller and Auditor General in regard to the health service made a number of recommendations and we believe our implementation of the key provisions of the consultant contract 2008 has significantly addressed these recommendations.

Chairman: I think Professor Drumm. May we publish his statement?

Professor Brendan Drumm: Yes.

Chairman: Before I ask Deputy Broughan to open questioning, I would like to clarify an area of confusion which arose at our last meeting. Professor Drumm mentioned that because of the loophole in regard to private patients in public hospitals, there was a loss to the HSE of €50 million per year. He later clarified the figure as being €23 million. What is the current estimated loss to the HSE because of that loophole?

In regard to the negotiations on the new contract, I understand a number of consultants' reports were done to deal with the mix of public and private patients. May we have copies of those reports? I understand a second McKinsey report was done. A further report was done by a company called PA Consulting.

Professor Brendan Drumm: I am not sure there was a McKinsey report but a company called PA Consulting was involved in setting up the measurement system.

Chairman: I understand McKinsey did one in November 2007.

Professor Brendan Drumm: I have to check that. I am not aware of it.

Chairman: May the committee have copies of both of those reports? What did PA consulting recommend before the HSE entered into the negotiations?

Professor Brendan Drumm: The creation of a system of accurately measuring consultant activity is a hugely complex issue. Measuring what somebody does in an outpatient department versus what somebody does in a coronary care department and measuring whether a piece of activity is ten times more complex or less complex than another piece of activity has not been done anywhere up to this point. It was used to help come forward with a system which had to be agreed with the consultants. The contract could not enforce this in terms of the specific measurement system. It had to be agreed with the consultants that the units we were measuring were accepted as being accurate.



We can give the Chairman the report. I am not aware of McKinsey's involvement in it but we can check that for the Chairman. We will give him the PA Consulting report. This is a hugely complex undertaking and needs agreement.

Chairman: I understand that.



Professor Brendan Drumm: Its involvement would have been to help to establish this. We will give the Chairman that report.

Chairman: Could we get the cost of these reports?



Professor Brendan Drumm: Absolutely.

Chairman:   What about the first question I asked about the loophole?

Mr. Liam Woods: Our best estimate at this stage is in or around €25 million and €30 million. There are a number of factors affecting income, so we are estimating that.



Chairman:   What is happening in the Department to deal with that loophole?

Mr. Michael Scanlan: There are two things. On the actual figure, the initial estimate we got in the Department was €67 million or €70 million. The figure of €50 million was then mentioned. I had heard about the figure of €23 million. I do not think there is a figure in the Comptroller and Auditor General's report, although I am open to correction on that. I do not think he mentioned one.



Chairman:   That is why I ask. There seems to be major confusion between the figures of €70 million, €60 million, €30 million, €25 million and €23 million.

Mr. Michael Scanlan: We asked for the basis of the calculations showing what this loss would be. I have not received that yet.

In terms of what is happening in the Department, I said in my opening statement that the Minister has made clear her position on this. She has answered several parliamentary questions in the Dáil making it clear that, as far as she is concerned, patients admitted under type A consultants are public patients and hospitals cannot treat them as private patients.

Chairman:   I am amazed because this arose at a meeting in June or July. It is now November but we still do not have a definitive figure. Is Mr. Woods saying €30 million?

Mr. Liam Woods: Part of the complexity in this is that there would be some substitution because there are private patients who are not being charged who could then be charged. A fairly complex calculation needs to be undertaken to get the net loss based on type A. When I say "estimated", we are allowing for factors such as the possibility that charging from other consultants could grow because we have private patients who would not have been in a designated bed and who may now be in one and be chargeable. It is a complex calculation and there is much work to do. If there is any confusion around the numbers, it will take us a while to bottom out that.

Chairman:   Is it fair to say that because of a defect in the new contract, this loophole is costing the taxpayer?

Mr. Michael Scanlan: No. We should stick with the figure for a minute. I think it is a fair question. As I understand it, this loss would only arise if, essentially, there was a private designated bed which could not be charged for in future, or could not be charged for at the rate it had been charged for up to now for some reason under type A. One of the findings in the Comptroller and Auditor General's report was that many private patients are in public beds.

I think what Mr. Woods is saying is that there is an obvious option that at the moment we do not have enough private designated beds to cater for those patients who are correctly admitted under other contract holders. We can now charge them. I have not seen any figures yet which show there is a loss, before we even talk about how it has arisen. That is also what the Minister has said.

Chairman: We are being told by the HSE that there is an estimated loss of €30 million as of now.

Professor Brendan Drumm: We may never have an accurate figure on this. In fact, I do not believe we ever will have one. The Secretary General is right that it will vary across different hospitals depending on the availability of private beds.

The truth of the matter, which I will put quite simply, is that if I go into hospital tonight as a private patient and it is to a category A consultant, I am no longer a private patient. That does not even register on our system, so we do not know that is lost income. That will not register on our system as one will go in as a public patient.

If I go into hospital tomorrow night and it is to a category B consultant or whatever, I will be chargeable and I can take up a private bed. That is the policy and that is fine. Rather than suggesting one will come up with an accurate figure, I think it will be a ballpark figure rather than an accurate one because I will not be seen as a private patient coming into the system.

Chairman: Professor Drumm raised it at one of our meetings. He said there was a €50 million loss to the HSE because of the so-called loophole. Now we are being told it is €30 million. Professor Drumm is now telling me it is a kind of technical figure.

Professor Brendan Drumm: At all stages we have said this is an estimate. In a stable environment in which private income remained relatively stable from year to year, we probably could be able to see a drop or otherwise in income. The number of people insured is changing. To be perfectly honest, it will be extremely difficult to come up with a figure, having explained to the Chairman how the system now operates.



Chairman: That is the unfinished business from the last day. I call Deputy Broughan.

Deputy Thomas P. Broughan: I welcome Professor Drumm and his colleagues from the HSE and Mr. Scanlan and his colleagues from the Department.

I am interested in the point Professor Drumm made in regard to measurement. Since last May the HSE has been trying to put in place some measurement systems in respect of private practice. It seems that all of these systems had to be developed in the aftermath of the consultants signing the contract. In other words, the contract itself did not contain any such systems. Professor Drumm made a good point with regard to the clinical directors. However, does measuring the level of private practice not present a major problem, particularly in the context of its exceeding the limits laid down in the contract or some pre-contract document? According to the Comptroller and Auditor General, some consultants actually signed the wrong contract.

Professor Brendan Drumm: We have arrived at a very robust measurement system. In response to what the Chairman stated, we will provide the committee with details of that. Historically, public-private activity has been measured on the basis of the number of public and private patients seen by a consultant. One could manage that very successfully and deal with some very long-stay, high-earning patients for high complexity work on the private side, while dealing with other patients on the public side. That was not a fair system. The system now in place even measures the complexities involved.

We are extremely satisfied with the robustness of the measurement system. What we must now take on board is the fact that the data is three to four months in abeyance because it comes through our HIPE system. We need to take the results of this to individual consultants. There is a standard process in place to deal with people who are in excess of what is laid down. Under this process, they will be able to row that back because there is certainly not compliance across-----

Deputy Thomas P. Broughan:   In recent days it emerged that 22 consultants were warned by staff of the HSE in respect of the amount of private practice they were carrying out. Apparently, the level of such practice was far in excess of the 70:30 split in respect of category B individuals. It is alleged that these consultants, in contravention of the contract, may have been conducting private practice up to a level of 40% plus. Is that the case? Were warnings only issued to 22 consultants? On foot of the backlog, is it likely that further warnings may be issued? Given that the contract has only been in existence since May, can we expect that many more consultants will be warned? Have any further warnings been issued since we received this report?

Professor Brendan Drumm: The Deputy can expect that further warnings will issue. We are in the early stages of the process. The introduction of an 80:20 or a 70:30 split represents a significant change to the system.

We always knew we would face a challenge in respect of cases where a big city, such as Limerick, or smaller towns might not have private hospitals. While 50% of the population have private insurance, there was always potential for a situation to develop whereby a large number of emergency admissions would claim private status. One will see huge variances as against, for example, a private hospital in Dublin. This does not mean that consultants are making money in a different way. However, it does mean that we must recoup that money for the hospital system. That is why, as already stated, there will be a process. Said process must be undergone in instances where that which I outline is happening. I suspect that it will, for the reasons to which I refer, occur in some geographic areas. If that is the case, we need to recoup the money and ensure that it is invested in the hospital system. Mr. Hennessy is probably in a position to provide information on the numbers involved.

Mr. John Hennessy: The new contract provides important mechanisms to measure levels of private practice. As Professor Drumm stated, it is case-mix adjusted in order to account for complexity. We are producing reports on a monthly basis and hospital managers and clinical directors are proceeding with the business of enforcing the control limits that are in place. There is a need to acknowledge the major work done by the ESRI in respect of the development of the

measure system. Quite an amount of study and reflection was necessary on its part and there was also a need for agreement with the consultants in respect of a mechanism.

With regard to implementation, as of this week some 85 consultants have been formally alerted in respect of compliance issues. This means that formal notices have been issued to them by their hospital managers. That number is relatively small when one considers that over 2,000 consultants are contract holders. I suspect that there will be more to come in respect of this matter. While the figure is significant, it is small when taken as a proportion of the overall number of consultants.

Deputy Thomas P. Broughan: In the context of sanctions or penalties, Professor Drumm seemed to indicate that there may be some clawback mechanism in instances where contracts are not fulfilled. What sanctions are available and what, if any, penalties have or will be imposed on consultants who are not compliant in respect of their public work?

Professor Brendan Drumm: I will ask Mr. O'Brien to deal with that matter. However, I wish to reiterate that many more notices will be issued. The figures available indicate that this will definitely be the case.

Deputy Thomas P. Broughan: Is Professor Drumm of the view that some hundreds or perhaps up to half of the over 2,000 consultants who signed the contract will be issued with notices?

Professor Brendan Drumm: It will not be half. In fact, it will not be anywhere near that number. As a result of the abeyance period to which I referred, the first sign-off in respect of our figures is due to take place either next week or the week after. However, we would be quite happy to make-----

Deputy Thomas P. Broughan: A consultants' contract was put in place in 1997 and a further contract for university consultants emerged in 1998. Many people are of the opinion that some consultants drove a coach and four through and blithely disregarded those contracts. I warmly welcome the fact that, at long last, compliance is beginning to be achieved. One expects that the terms of a contract mean what they say. If there is to be much greater equity with regard to the treatment of public patients, then it seems that this is the route we must take.

Professor Brendan Drumm: The Deputy will get full agreement from us and from the majority of consultants who operate correctly within the terms of their contracts. He is correct - the Comptroller and Auditor General would have identified this fact - to state that in the past the contract would have been open to a high level of non-compliance. The new contract represents a huge step forward. We would be happy to provide the relevant figures to the committee and members will be in a position to see that notices will be issued to hundreds of consultants. However, it must be remembered that we are in the early stages of seeking their compliance. Perhaps Mr. O'Brien will elaborate further on this matter.



Mr. Barry O'Brien: The contract specifically highlights an important element to which we refer as mutual obligation. It states, "Both the Consultant and the Employer recognise the need

for mutual trust, confidence and respect in giving effect to the terms of this contract.” It also states that a consultant shall participate in such arrangements as are put in place by his or her employer to verify the delivery of his or her contractual commitments. Section 20 of the contract deals specifically with the mechanisms relating to the remittance of private fees where a consultant exceeds the contractual ratio of public to private practice. It states:



The Consultant will be advised on a timely basis [namely, the monthly report] if his or her practice is in excess of the 80:20 ratio of public to private practice in any of his or her clinical activities. An initial period of six months will be allowed to bring practice back into line [with the approved public-private ratio mix] but if within a further period of 3 months the appropriate ratio is not established (s)he will be required to remit private practice fees in excess of this ratio to the research and study fund under the control of the Clinical Director.

Clinical directors will, therefore, have an executive role to play in respect of engaging, on a monthly basis, with consultants with regard to the outcomes relating to their public-private ratio mix. There is a clear, specified timeframe in that regard.

The HSE has robust HR policies which will come into play after a nine-month period if a consultant is not operating within his or her public-private ratio mix. We have not yet reached that point yet because the data in the possession of consultants is in arrears and relates to February, March and April. They must be given a further six months. Section 20 of the contract is specific with regard to the mechanism the employer can use in order to ensure full compliance.

Deputy Thomas P. Broughan:   In effect it would be a clawback of income earned by the consultant outside the terms of the contract, which would be available for the HSE service in that location.

Mr. Barry O’Brien: The contract provides that the consultant will provide evidence of total private fee income related to the cohort of practice, including inpatient, outpatient or day cases in excess of the specified ratio, to the employer. Such evidence shall comprise all material related to the cohort of practice, claims submitted to health insurers and such documentation as is necessary to account for the amount of private fee income received in respect of the cohort of practice. It goes on to say that the employer shall be entitled to seek further and-or satisfactory evidence of such income. The provision is specific. The consultant who has signed the contract is aware of the terms and, therefore, as they refer to the mutual obligation, he or she is committed to giving full regard to that.

Deputy Thomas P. Broughan:   I thank Mr. O’Brien. Professor Drumm mentioned the most up-to-date figure of 2,350 as our current complement of consultants. Due to the public service embargo it has been the case that if a new, much-needed consultant was to be taken on, two ordinary hospital doctor posts would have to be suppressed. Was that implemented as the new posts came on stream?

Professor Brendan Drumm: Most of these posts would have come on stream before the embargo, but that requirement is now the case. Most of the posts in question were posts that were in abeyance while the contract was negotiated, because we were not willing to issue old

contracts. The posts would have existed pre the change. Currently, we have approximately 5,000 junior hospital doctors and their posts are considered training posts. It is irrational for any system to have 2,500 consultants and 5,000 people in training to replace them, considering training a person takes a maximum of seven or eight years, but the average consultant will work for 30 years. The maths do not work out. It is more reasonable for us to convert those posts and that is our focus.

Deputy Thomas P. Broughan: The information we are beginning to get through verification and, hopefully, through the clinical directors, is important because we in the Oireachtas and the Department must make public policy in this area. Therefore, we need to know the number of positions that are required and what we should aim for. What figure for consultants does Professor Drumm see as being required? Not to raise recent controversies, many members of the public have been upset by the issue in Professor's Drumm's old workplace where there is a waiting list of 130 children waiting for much-needed heart operations because the number of theatre days required are not available to facilitate those operations.

A woman who visited my weekly clinic last Saturday told me that even though her GP had a grave concern about her condition she was given an appointment to see a consultant in the neurology area for March 2011. People find this kind of treatment disappointing and disheartening. Is this problem related to the number of consultants and do we still need to expand numbers to create the best possible system for the people? Obviously, we have significant budgetary discussions to conduct over the next month and these may have a bearing on numbers.

Professor Brendan Drumm: The answer is "Yes" we do, but it is not a simple issue. There are two main issues in this regard. Historically, until the establishment of the HSE, the Irish system was not performance managed. The data that was available on activity was all grossed-up data and it was difficult to break the figures down into individual unit performance. Our HealthStat data, which is on the website, shows huge variability in performance across the system. This is not easily aligned to the number of people working in the system. This applies to all areas, from social work to physiotherapy and to consultants. Therefore, it is not a simple matter to deal with. Unfortunately, when we have a waiting list here or when somebody is left waiting, the natural response seems to be to draw this to the attention of the media and suggest that if we got more nurses or doctors, the waiting lists would not exist. The evidence that this would solve the problem is very poor. In fact there is significant evidence to the contrary that performance can be poorer when numbers are high.

We are now in a position to improve the number of consultants and this is already driving change in some of the areas mentioned by the Deputy.

Chairman: With all due respect, I do not think that is what the public suggests. The public do not say we need more consultants or nurses. They say if there was proper control of public and private business in hospitals, there would be greater access for public patients. Their question is why, if they are willing to pay a certain amount for a procedure, for example, €10,000 or €12,000, they will get a place immediately in a public hospital, but if they cannot pay, they will be left waiting indefinitely.

Professor Brendan Drumm: I agree fully with the Chairman on that issue. However, irrespective of whether the system is public or private, the throughput per head of employee in our system has been very variable. If the instant response where somebody is left waiting is that more people are required to resolve the issue, that evidence is not in our HealthStat data. There are situations, however, and the Chairman is right in this regard, where more staff will resolve the issue. Therefore, by converting more junior doctors to consultants, we will get a consultant-provided service and there is no doubt that this will greatly help in areas like anaesthetics in Crumlin, where there has been a major blockage. This is something we think will make a difference.

With regard to issues such as outpatient lists for neurology, etc., there are a number of areas where outpatient waiting lists are an issue. Outpatient waiting lists are an issue the HSE itself voluntarily took on. These had not previously been managed, but we now put that information into our HealthStat data, thereby actually beating up on ourselves. However, our approach is the only approach to take, because outpatient waiting lists are the biggest problem in the Irish health service.

Deputy Thomas P. Broughan: Does the HSE intend to expand on what it is doing in that area? It has a common waiting list now for colostomies and endostomies. Is that the beginning of an improvement in this area?



Professor Brendan Drumm: It is accepted that there is nothing to stop consultants with specific contracts from continuing to run private practices outside of the system. This happens in a number of areas one of which, urology, was mentioned by the Deputy. Others include ENT, orthopaedics and dermatology. Currently, we have focused on these latter three and are running a specific project that will help us get rid of the extremely long waiting lists in these areas. We have found that although people may have to wait up to two years, the total number of patients waiting above six months is very small. Through the clinical directors we are now focusing on providing extra clinics, etc., to deal with the situation. This is why the work of clinical directors is so relevant. Measurement is only a relatively small part of the need for clinical directors. What we need them for is to do what the Deputies have been talking about. We need them to ensure that people do not end up getting an appointment for two years down the line to investigate an issue that should be seen to now. That is an area in which clinical directors are beginning to have a significant impact.

Deputy Thomas P. Broughan: I would like to return briefly to the new structure, with the A, B and C type contracts. The Comptroller and Auditor General had the figures in this regard. Some 37% of the consultants on A contracts are now in full public practice. The work of newer people on B contracts is 80% public and 20% private and that of the older people is 70% public and 30% private. Then we also have those on C type contracts. With regard to the newer people appointed, what are the latest figures for each category? How many more As have we gained? What is the full number of Bs and Cs?

Professor Brendan Drumm: I have those figures. It is extremely important that when we look at the breakdown between As, Bs and Cs we notice that specific specialties have clustered. Low-earning specialties, if we can call them that, have clustered. Therefore, we find a large number of

psychiatrists, geriatricians and paediatricians clustered in A and some of the surgical sub-specialties, such as cardiology, lowly represented in the A group. Also, people opted for contracts based on the fact there was not significant private money to be made for some reason in their specialty.

The numbers, as before me now, are that of the 2,350 there are 682 on A type contracts, 84 of which are new posts. There are 1,005 on B type contracts, 320 of which are new posts. This type B star which is just available to people who are already on contracts - it is not available to new people - is 338 so that fits into the B category. The system still contains old category one people who did not change contract - 62 from what I can see. They were people who could work with unlimited private practice within a public hospital. The old category two gave people a licence to work anywhere, anytime and 188 have remained with that contract. The academic consultant contract has not yet been offered to everybody yet, as I think it has not been fully completed so it is probably not relevant.

Deputy Thomas P. Broughan:   The Comptroller and Auditor General supplied a figure to the committee. There seemed to be a very low take-up of 50%.



Professor Brendan Drumm: I do not think that is an issue of take-up.

Mr. Andrew Condon: The issue of the academic consultants is in the control of the universities and not in the control of the HSE. A portion of the HSE Vote was allocated to the Department of Education and Science, subsequently to the Higher Education Authority and subsequently to the universities to support that offer. The control of the offer is with the HSE.

Professor Brendan Drumm: Therefore, that 50% might not be a very accurate figure.

Mr. Andrew Condon: That 50% is a dynamic figure. The offer is ongoing.

Professor Brendan Drumm: I think it is maybe more to do with what is being offered rather than what is being taken up. It would be necessary to go back to the universities to see if perhaps this is all they have offered.

Deputy Thomas P. Broughan:   Within the B grade, how many are on the old 1997 contract, the 80:20, or are they all new people?

Professor Brendan Drumm: Some of the old people will also be within 80%-20% because there was a provision in the contract that a person operating under 20% could not suddenly move it up so some of the old contracts will be ----

Mr. Barry O'Brien: It was dependent on the data. A specific time was agreed in the data analysis. A person could be a variable, be 24%-76%. One did not automatically go to 70%-30%.

Professor Brendan Drumm: New contract personnel will have to be 80%-20%.

Deputy Thomas P. Broughan:   Were those people off-site?

Professor Brendan Drumm: It would be the equivalent of the old category two contract which allowed a person to work anywhere in a hospital.

Deputy Thomas P. Broughan: I have a question for the Department on public policy with regard to this matter. Many people will welcome the category A contract. However, by proposing a category B, for a significant number of consultants we have diluted the old commitment in the 1997-98 contracts to have an 80%-20% split. We have gone backwards rather than forwards. What would the Department say about equity in the provision of the health service?

Mr. Michael Scanlan: I do not think we have gone backwards. As the Deputy said, the old contract was not as explicit but it stipulated that the mix should be 80:20 which was the bed designation mix. As the Deputy observed what happened was that in reality, practice varied. The new contract stipulates that every single new appointee is at 80%-20% and any of the existing people can hold what they had, subject to a maximum of 30, so it is coming forward.

The Chairman made an important point about what we are trying to achieve which is to measure waiting times for access to services by both public and private patients. If we focused on that as being what we want to achieve and measured it, then the Chairman would be correct about the levers now in place. In terms of the future, all the B category people will be 80%-20% and cannot be higher than 80%-20%. I will admit we have to look at the figures but we have levers to decide on the mix as between category A and category B contracts. It is not as of right that a new appointee can decide which category. If a target is set, as the Chairman said, and if it is not being achieved, the levers can be changed. This is what is different, along with the measurement.

Deputy Thomas P. Broughan: We are hoping the outcome for public patients will be significantly better and Professor Drumm has given some reassurance in this regard. I note from the investigations by the Comptroller and Auditor General that the total bill for consultants in 2006 under the old contract was approximately €50 million. I have some detailed figures and I will return to them later. What will be the total HSE bill this year for all consultants with the new arrangements beginning to emerge? What will be the pay bill?

Mr. Michael Scanlan: I will come back to the Deputy with that information. The cost to the Department this year was €5 million for the new consultant contract. This was the amount of money we had to provide-----

Deputy Thomas P. Broughan: Additional money?

Mr. Michael Scanlan: Yes, additional money.

Deputy Thomas P. Broughan: The country has deep fiscal problems. Is it possible there are other arrears of payment owed to consultants as a result of the management of the introduction of the contract?

Mr. Michael Scanlan: I made the point in my opening statement that moneys were due last year amounting to just under €70 million and under the terms of the contract, a further increase

was due from 1 June 2009 which has not been paid. One could apply the term “arrears” to both of those figures.

Deputy Thomas P. Broughan: So there could be arrears of €150 million. I was just adding up the numbers of consultants, on the basis of 2,000 consultants and we have more than that figure now. On the figures which were provided by our backroom staff for a range of consultants, one could be talking about a global bill of €500 million for 2009.

Mr. Michael Scanlan: No. I take the point that one could add both the €70 million and the €85 million we saved onto the €95 million and the €350 million. That would not be a 2009 figure. This also presupposes that the €70 million and the €85 million will be paid.

Chairman: Arising from Deputy Broughan’s questions and with regard to the HSE internal audit on adherence to the contracts, have all hospitals co-operated fully with the audit?

Mr. Barry O’Brien: The internal audit identified some concern with eight separate contracts and this has been fully rectified. One hospital had an initial problem with the audit but has since fully co-operated. I can confirm that all hospitals, both in the public and voluntary sectors, have fully co-operated.

Chairman: Some astounding figures were reported in a daily newspaper recently where in one particular case, all procedures carried out were on private patients, 100% of procedures, and other figures were 42% and 40% of private procedures. How is this being allowed to continue?

Professor Brendan Drumm: The HSE has to claim back that money if that remains the case. I refer to Limerick Regional Hospital or St. John’s Hospital in Limerick. In that region more than 50% of the population have private health insurance, therefore, without an alternative facility to provide private care, it is likely those hospitals will have high private rates of occupancy. The HSE must ensure that any amount above the figure of 70%-30% or 80%-20%, as it applies, is repaid to us.

Chairman: That 50% is a national figure. How does Professor Drumm support the statistic that 50% of people-----

Professor Brendan Drumm: That is certainly not a national figure but there will be places in the country where that figure will apply.

Chairman: What about the cases where 100% of procedures-----

Professor Brendan Drumm: The national figure is actually way lower than that.

Mr. John Hennessy: Yes, it is. The Chairman may be referring to the insured population which we understand is about 52%.

Professor Brendan Drumm: The national figure of 52%. I apologise. I misinterpreted the

Chairman. I will outline what will happen where there is a private hospital or a number of private hospitals. For example, I believe there are two or three private hospitals in Galway city. The ratio of private practice coming into Galway university hospital is likely to get much closer to 80:20 very quickly than it is down the road in Limerick where there is no private hospital and 50% of the population is still private. I am not saying that we do not need to get that money back, but there will be huge variations.

Chairman: Further down the road in Cork there are a number of private operations, with 100% private in one particular specialty.

Mr. John Hennessy: In a particular specialty, perhaps, but we certainly are not aware of any hospital operating at 100% private - far from it in fact.

Chairman: So the figures were wrong.

Professor Brendan Drumm: We would have to get that information from the Chairman and we can check it.

Chairman: I was just reading from a press report of 1 October.

Professor Brendan Drumm: As I said we will get that from the Chairman. We will check it and see.

Deputy Michael McGrath: I welcome Mr. Scanlan, Professor Drumm and their colleagues. When researching for today's meeting, I was struck by an item which will surprise many people. It is the distinction between chargeable and non-chargeable private patients, and the fact that only 50% of private patients in the public hospital system are chargeable. It is important to tease out the reasons for that in terms of the bed designation system, the policy decision regarding type A consultants and so forth. If 100% of private patients were being charged through their health insurance premiums how much money would that represent?

Professor Brendan Drumm: First, the type A thing is the small end of that 50%. It has more to do with how beds have been designated historically. While it varies from hospital to hospital only 20% overall are designated. We ended up in a situation where if a patient ended up in a non-designated bed, the consultant could charge him or her but we could not charge him or her. Do we have a figure on what a 100% charge would be?

Mr. Liam Woods: It might be helpful to look at 2009 and annualise September's figures for the whole system, both voluntary and HSE. We would anticipate a combined private income of €376 million, against a year to date figure of €280 million. The current charging practices and arrangements give rise to €376 million estimated for a full 2009 year. The question then that I think the Deputy is going after is what portion remains uncharged and what would that charge be. There is complexity in the second piece of that question because it very much depends on what is happening. If there is a 50% undercharge and it was the same kinds of cases then it may be a simple sum, but in fact it would depend very much on the kinds of cases that are not

being charged for. It would be something we would have to look further into to estimate it.

Deputy Michael McGrath: In general terms, is Mr. Woods saying that the charge in respect of the chargeable private patients is approximately €376 million for the year? If only 50% of the private patients are chargeable a reasonable assumption is that the same figure would represent the other 50%, which in effect is the loss.

Mr. Liam Woods: If they were similar cases.

Deputy Michael McGrath: In general terms, taking into account the different variables involved the figure would be approaching €400 million in respect of private patients utilising public hospital facilities where their health insurer is not being charged in respect of that. I know it is a policy issue in respect of the bed designation system. This is the elephant in the room in the context of the debate given that it is approaching €400 million.

Mr. Michael Scanlan: It is a policy issue. In fairness, I still can say something I can feel about it. It goes back to what one is trying to achieve. If one is trying to achieve an appropriate access for public patients, I would agree with the Comptroller and Auditor General and the committee that the current arrangement therefore is not satisfactory. It is not satisfactory that whatever the sum of money out there is, there is a mix and money is not being collected. What I would say is that the policy solution, if that is the right term, is to change the mix rather than stay with the current mix and collect the money. That is the only and important caveat that I was trying to put into my opening statement.

Deputy Michael McGrath: In effect if a private patient is not put into a designated private bed under the current system, the hospital cannot charge for the accommodation costs involved. The consultant can charge for the services he or she provides. That seems to be a very unsatisfactory system. To what extent can Mr. Scanlan be confident that the bed designation ratios are correct and represent the reality of the public-private mix in terms of the people coming into the system?

Mr. Michael Scanlan: Again, I think it is a fair question. I think I would say that the information that will now start to emerge about the actual public and private mix of individuals and also if we start to measure waiting times, makes that a question that we in the Department would need to look at. As of now the policy position was that when the bed designation system came in, it was to reflect the 80:20 ratio. Even at that stage if I think back, there was approximately or just over 40% private health insurance. It was never intended to reflect the full scale of the population that had private health insurance. It was always seen that they had somewhere else to go. Depending on the new consultant contract driving down the mix to where we want it to be, a lot of this in a sense is moot if we could get to a stage where we got good access by public patients to a public health system. That is the core of what we need to get to.

I am very conscious that this is a complex policy issue. All I would say is that from my perspective I would certainly look at the facts, look at the figures and then advise any Minister about what if any change has to be made. At this point in time, in fairness the Comptroller and

Auditor General mentioned that one needs to look at the interaction of the bed designation and the contract. In my view it would be way too soon to change the bed designation system until we see actual results in terms of shift of public-private mix with the new consultant contract, and until one looks at all the other levers I mentioned like the new category A.

Deputy Michael McGrath: Whatever way it is dressed up, at the moment the effect of the current system is that taxpayers are paying a subsidy of up to €400 million in respect of private patients in the public hospital system. That is the bottom line.

Mr. Michael Scanlan: From my perspective, in terms of the policy objective, the weighting in favour of private patients is too high. In one sense one could say it is the same thing. My focus on it is not the income but rather what we are trying to achieve in terms of public patient access.

Chairman: While we are tiptoeing around the situation, Deputy McGrath's point is that public beds are being blocked by private patients because the consultant is getting paid anyway. The public hospital is not getting paid. The taxpayer is suffering and the public patient is suffering.

Mr. Michael Scanlan: Absolutely.

Chairman: There is a tiptoeing around the core issue in all this.

Mr. Michael Scanlan: I hope that I am not tiptoeing, but the Chairman is absolutely right. I guess the only question - the core question - is what the right solution is. Is it to recover money or to unblock those public beds and free them up for public patients? That is the only point.



Chairman: Our concern would not be the money but that there be fair access for people entitled to a treatment and who are suffering. Considerable queue jumping is going on because there is a private business operating within the hospitals. The taxpayer and more importantly the patient is suffering. I saw it in practice last week in Cork. The reality in Cork is that people cannot get on a waiting list for orthopaedic outpatient appointments. People are told they cannot even get on the list. If they are prepared to take out a credit union or other loan they would be dealt with almost immediately.

Mr. Michael Scanlan: I think that I am agreeing with the Chairman that that is the core issue. Perhaps unusually, for once, it should not be money generation that is the core issue. I take the point about value and subsidy or whatever word one wishes to use. I think that is the core issue. That is where we need to go rather than in a sense accept the current position and simply collect the income.



Professor Brendan Drumm: It is an important question. Coming back to the earlier questions on 80:20, certainly in the present situation if we can impose - and we have to - our ability to collect that money, then everything that is above 80:20 or 70:30 should actually be coming back into the system. So more designation is best in that situation because we would be taking the money back into the system and it would not be an incentive for the consultant to do it for a

personal reason. There might be an incentive for a group of consultants to do it for their institution, or whatever, if it was going to come in. There are ways around this.



Mr. Michael Scanlan: There is an important other way in which this might work. A consultant facing the loss of his private income, in the circumstances alluded to by Professor Drumm, has another choice. We were conscious of this when we designed the contract. Instead of giving up that private income, he can increase his productivity for public patients. That is where we return to the stuff Professor Drumm was talking about earlier - the need to measure the actual efficiency of the operation at each hospital. If such a consultant brings in more public patients rather than almost deliberately creating a market, as may have been happening up to now, he can hold on to his money and the public patient will benefit.

Chairman:   Surely the solution would have been to offer such a consultant a sufficiently high salary, and to tell him to forget about his private practice and get on with his public work. Why was that not done?



Mr. Michael Scanlan: It was. That is the type A system, in effect.

Chairman:   Why was the alternative offered?



Mr. Michael Scanlan: Public policy for many years has been to have a mix.

Chairman:   It is a question of policy.

Mr. Michael Scanlan: As the Chair has said, it should not be an uncontrolled mix.

Deputy Michael McGrath:   I would like to look at this at a very simple level. Mr. Hennessy said that more than 50% of people have private health insurance. What is the average ratio under the national bed designation system? Is it the case that there are 80% public beds and 20% private beds?



Mr. Michael Scanlan: Yes, the ratio is 80:20.

Deputy Michael McGrath:   A significant proportion of the private patients coming into the system are occupying beds which are designated as public beds and are, in effect, not chargeable.

Mr. Michael Scanlan: One has to take account of the capacity that exists in the private hospital system, outside the public hospital system altogether.

Deputy Michael McGrath:   I understand that.

Mr. Michael Scanlan: The 50% of the population who buy private health insurance can go into two places. One would have to check how many of them go into private hospitals.

Deputy Michael McGrath:   Can Mr. Scanlan give me the answer to that? What

percentage of patients who have interaction with the public hospital system are private, or have private health insurance cover? What percentage of inpatients in our public hospitals have private insurance cover? Is it 20%, 30% or 40%?

Professor Brendan Drumm: It varies in different parts of the system.



Deputy Michael McGrath:   I am looking for a ballpark, or average, figure.

Mr. Liam Woods: The figure is approximately 25% or 26%.



Professor Brendan Drumm: In areas with no significant private hospitals, the figure will hit 40% or 45%. At the end of the day, 80% of admissions are acute, or emergencies. We can get the national figure, which is probably in the order of 25% to 30%, for the Deputy.

Mr. John Hennessy: It is very difficult to compile a single national figure because it is not simply a matter of adding up all the hospitals and dividing by 50. It is a little more complicated than that. The range goes from the mid-teens, up to 40% or more in some hospitals

Professor Brendan Drumm: This is information we can give the Deputy if he feels it would be helpful.

Deputy Michael McGrath:   I think it would be. It is a critical point. We have been told that in certain hospitals, 40% to 45% of inpatients are private patients. The average designation of public beds is approximately 20%, which means that between 20% and 25% of beds are used for private patients who are not chargeable. It seems completely illogical. This is first time I have looked at this in any detail.



Professor Brendan Drumm: That would be the case.

Deputy Michael McGrath:   It will come as a surprise to a great many people.

Mr. John Hennessy: It will. Limerick is a good example of an area in which there is no alternative private inpatient hospital.

Deputy Michael McGrath:   Yes.

Mr. John Hennessy: Some 80% of the work that comes into the hospital in Limerick comes through the accident and emergency department anyway. It is one of those things all right.

Deputy Michael McGrath:   I would like to ask a supplementary question about a new contract. To what extent can consultants fill their 80% public commitment by having private patients in public beds? I refer to cases in which the hospital cannot charge for that patient, but the consultant can charge for his services?

Professor Brendan Drumm: The new contract is based on the patient day charge, rather than on what we charge. We will be aware of any patient in any bed who is private, from the point

of view of the consultant, even if we are not charging. We take account of his or her activity, rather than our private activity.



Mr. Michael Scanlan: While it would be interesting to look at the figures, we should look at the elective and emergency sides separately. Many people have expressed concern about the elective side. I think that is important. The other thing is to be clear. When I made this point previously, a member of the committee made a comment about the reality on the ground. One is not private, in our terms, just because one has private health insurance. It is important to remember that a person with VHI cover can continue to turn up and get public services. I am not being denied the service. I accept that it is not right, in a sense, that a consultant can earn a fee in respect of a patient for whom the hospital cannot charge.

Deputy Michael McGrath:   Yes.



Mr. Michael Scanlan: The solution is-----

Chairman:   One does not have to queue for the private, that is the point.

Mr. Michael Scanlan: That is why I said I agree with the Chairman that one should start by measuring the exact waiting time for access before working back from that. If it is not satisfactory, one should examine how one can change it.

Deputy Michael McGrath:   Obviously the recession means that many families are struggling to cope with their financial commitments. As their bills come in, many of them are regarding their health insurance premiums as a luxury and are choosing not to pay them. There has been a very significant reduction in the number of people who are renewing their health insurance premiums. What are the financial implications of that trend for the HSE? Patients will continue to come into the hospital system, but more of them will not be chargeable because they do not have insurance cover. Can the officials tease out the financial implications for the HSE of the reduction in the number of people with private health cover?

Mr. Liam Woods: It is clear that a decrease in the total volume of private-paying business in hospitals would have an immediate and direct effect. I would like to refer back to one of the Deputy's previous comments. There is a sense in which there is a level of cushioning. I refer to the volume of work that could be charged if it were done in a private designated bed, but is not being charged. It is identified on one of the pages of the Comptroller and Auditor General's report. The Deputy identified it when he raised the 50% figure. There is some cushioning in terms of what is going on from the HSE's perspective. It would depend on the extent of any trends that would emerge.

Deputy Michael McGrath:   Can Mr. Woods quantify what the impact is likely to be, for every 10,000 or 50,000 people who do not renew their premiums?

Mr. Liam Woods: I cannot do that directly. If one draws on the data in the Comptroller and Auditor General's report and the observations the Deputy is making, this type of work would have to decrease by half before it would become a financial issue. We are charging 50% of

those private patients who are admitted - the others are in public beds or non-designated beds. From our point of view, there certainly will be a clear effect when it drops below half. I cannot translate that into a number of members because I do not know what proportion of VHI members are likely to make a claim, by comparison with the proportion of them who are healthy.

Deputy Michael McGrath: The financial implications of the decrease in the number of people with private health cover will be significant and will be adverse for the HSE

Mr. Liam Woods: It is likely to cause us a loss of income. It is difficult to assess the point at which it would actually hit the HSE. There is a time period for which it would not hit us, based on the current mechanisms of operating.

Deputy Michael McGrath: I would like to ask about the preparation and submission of claims to private health insurance providers. I understand that each hospital is responsible for the preparation and submission of claims, including the accommodation costs and the consultants' charges. Is that correct, even in the case of exclusively private practice? Does the hospital have to prepare the claim for the consultant and submit it? What are the administration costs involved in doing that? Why are hospitals not charging consultants for the administration costs involved in preparing these claims, which must be significant? How can we justify not passing on a charge for what is private business, in effect?

Mr. Liam Woods: The HSE is fundamentally changing the way it organises the collection and administration of charges. As Professor Drumm has said, we are moving to a central point of collection in Kilkenny. This project, which will run over the next 12 or 18 months, will reduce the level of administration and the number of people involved in administration. It will eventually bring all income collection to one point. As the Deputy has said, the practice followed in the billing sections of hospitals involves sending claims with two pieces - a consultant piece and a hospital piece - to health insurers. A sign-off is required on both pieces. Part of the rule set that was traditionally embedded in the health system involved a dual sign-off to attract payment. In some instances, there may only be payment to the consultant, not to the hospital. Therefore, the question the Deputy has asked - why would the HSE do that - is a fair one. Our position is that if we are to get income quickly, we need to get forms signed by consultants and into the health insurers.

The HSE charges based on regulations made by the Minister and does not have an independent capacity to charge. As for our present process, I wish to highlight that we are engaged in some work to accelerate the level of claims. We are dealing with approximately 90,000 forms, as Professor Drumm noted earlier, in advance of moving to a single site in Kilkenny.

Deputy Michael McGrath: Is the principle involved in passing on the administration costs of preparing such claims a matter for the Department rather than for the HSE?

Mr. Liam Woods: Our future reorganisation envisages a shared role in this regard. Our future organisation will be able to consider how this practice works. We can talk with the insurers about

how we envisage this working in the future and whether we need to continue a dual system in which, effectively, the two things go on a single piece of paper.

Deputy Michael McGrath: Other service providers in the economy who carry out work, such as carpenters, builders or architects, cannot ask another organisation to prepare their invoices. They cannot ask it to do all the work involved and to incur all of the associated costs. This does not seem justifiable.

Mr. Liam Woods: No.

Deputy Michael McGrath: Will this matter be reviewed?

Professor Brendan Drumm: On this link between the sign-off on the HSE's claim form, there has been an incentive in place whereby a hospital will get its money signed off if it ties it to the consultants' money. However, the Deputy is correct. As I noted at the outset, we could pick up our money quickly if we could just submit our bills for accommodation which----

Deputy Michael McGrath: Will the HSE examine this issue of passing on the associated costs?

Professor Brendan Drumm: We currently are in negotiations in this regard with the insurance companies. This certainly would get around most of the issue under discussion today about the collection of income.

Deputy Michael McGrath: I refer to the submission of claims to the health insurers. Typically, on discharge of an inpatient, how long does it take before a claim has been fully completed, signed off and submitted to the health insurer?

Mr. Liam Woods: On average, this has been taking up to six months in the health system for a number of years. The HSE has been seeking to address and radically change this timescale in recent months.

Deputy Michael McGrath: Is this from before the claim is submitted?



Mr. Liam Woods: No, it is from the date of the discharge of the patient.

Deputy Michael McGrath: How much of this six-month delay is accounted for in the hospitals during the preparation of the claim?

Mr. Liam Woods: The bulk of this timescale is taken up with getting consultant sign-off on individual claim forms. In part, it pertains to administration, that is, the preparation of a form, but the longest part of the wait before getting claims completed pertains to getting sign-off from consultants.



Deputy Michael McGrath: Would it be typical for a consultant to take a number of months before signing off on an individual claim form?

Mr. Liam Woods: Yes. Certainly there are lengthy delays in getting forms signed in a number of hospitals.

Deputy Michael McGrath:   Has efficiency in respect of getting claims signed off and into the system been addressed by way of the contracts?

Mr. Liam Woods: At present, we are accelerating this dramatically across the system. We currently are engaged in a project to improve this time and our target is to get to within 30 days of discharge for payment. At present, it takes more than 180 days.

Professor Brendan Drumm: I should state this is of practical relevance. At this point, we are running above service plan levels with regard to elective work and so on. As we can only maintain this level if we can improve our income, our capacity to keep going also has a huge effect on public patients. The alternative is to clamp down on elective work at service plan level after which we would end up with loads of staff doing very little while saving small amounts of money. Consequently, it is of great importance to the HSE to get in this money towards year's end in order to be able to continue with its elective work. There is a huge focus on this issue at present and I hope the consultants will co-operate on the basis that it also will benefit patients.

Deputy Michael McGrath:   How would Professor Drumm characterise the relationship between the HSE and the voluntary hospital sector with regard to the operational independence, for example, of a voluntary hospital that has its own board? To what extent has the HSE adequate oversight on how the grants being provided to the voluntary hospitals are being expended? Are the compliance provisions with regard to the consultants' contract, the claims process and so forth as rigorous in the voluntary hospital system as in the HSE public hospitals?

Professor Brendan Drumm: As an organisation, we have come a long way in the last couple of years. The relationship between the statutory and voluntary sectors now, as against the time when it was dealt with by disparate health boards, has changed greatly. Like all such relationships, it was quite tense at the outset and perhaps lacked some confidence on both sides. However, we now are in a position in which I consider that we have a highly constructive relationship with most voluntary agencies. I cannot state this is the case with all of them. We now are getting into much more formal service level agreements with such agencies. The Comptroller and Auditor General has dealt with this issue previously in respect of the disability sector, rather than of hospitals. However, the last few weeks have seen the beginnings of sign-off by the voluntary sector on a much more formal arrangement with the HSE in the future. The basis for this now is in place and it will be much better in respect of oversight in the future.

As for specific oversight, while I am not an expert the Comptroller and Auditor General probably is the only person who has the authority to go into such an agency. I do not think the HSE necessarily has such authority.

Mr. Liam Woods: Our arrangements with the voluntary sector or any third party provider are governed by legislation under sections 38 and 39 of the 2004 Act. Consequently, we have both requirements and the opportunity to have clear terms of trade with voluntary agencies.

Chairman: I wish to recap on two points. Is the public-private mix affected by a quota system? Some consultants have told me that although they could do a lot more work on private patients, a quota has been imposed by hospitals because of budget constraints. How big a factor is this?

Professor Brendan Drumm: Certainly, we try to operate within service plan level. Obviously, we cannot impose a quota on emergency work and we have no control over that 80% to 85% of our work that comes through the door on a daily basis. The Chairman is referring to the 15% to 20% of the work that is elective. At the beginning of the year, the HSE will set out a service plan-----

Chairman: That is the area in which most of the high levels of private practice takes place.

Professor Brendan Drumm: Absolutely. The HSE sets out a service plan at the beginning of the year stating how much elective work it intends to do in its hospitals. As I noted, we are above that level and have been for a couple of years. We have managed to do so through value for money savings. However, we do reach a point whereby we must tell individual hospitals that they cannot continue to admit people because we have not been funded by the State to do so and must bring in the Vote. Does Mr. Hennessy consider this to be a fair assessment?

Mr. John Hennessy: I think so. Obviously there are restrictions on activity as a result of cost containment and cost controls. This has been a fact of life in the health services for quite a while. However, I do not necessarily believe that the impact of the private practice limitations is having that effect on restricting activity.

Professor Brendan Drumm: This comprises cost containment within a service plan deliverable and is not unplanned cost containment. In other words, it is not overspending but is deliverable up to what we have committed and indeed beyond it.

Chairman: Am I interpreting correctly some of the replies given to Deputies Broughan and Michael McGrath by stating that within a short time, members will be able to get a breakdown of the public-private mix for every consultant that has a contract with the HSE? The witnesses should tell members when.

Professor Brendan Drumm: Yes, we will have a breakdown for individual consultants. While members can have our figures in respect of what is the breakdown for individual hospitals, there may be an issue as to whether the HSE can give to the committee the names of individual consultants. This probably is more of an issue for the committee than for the HSE. Is the Chairman requesting the HSE to provide this information?

Chairman: Yes. We have sought this information previously and were told the HSE could not give it to us.

Professor Brendan Drumm: Unless there is a legal embargo-----

Chairman: Although this information was given to the ESRI, the committee did not receive it. We formally seek a breakdown of the public-private mix for every consultant as soon as possible.

Deputy Róisín Shortall: I welcome the witnesses and thank them for their presentation. The backdrop to this meeting is the earlier session at which members sought to examine the previous contracts in some detail at which it appeared as though consultants were a law unto themselves and that there were few or no mechanisms in place to supervise their work. For this reason, the committee was keen to be reassured that mechanisms would be in place in the new contract to ensure value for money and that people were doing the work for which they were being paid. In this context, it is disappointing to hear from Professor Drumm that the coming months will likely see hundreds of consultants who are non-compliant with the terms of their new contract. It is a fairly damning judgment of our consultants and, if that is the case, it is a matter of serious concern to the committee.

I would like to establish some specific details of the new contract. What is the current value of each of the different contracts?

Mr. Barry O'Brien: Is that the salary?

Deputy Róisín Shortall: Yes.

Mr. Barry O'Brien: By way of information, we can provide the detailed salary scales, but members should be aware that all existing consultants who availed of the 2008 contract automatically went to the maximum point. Each scale for all new consultants has four increments. This is a key difference. All consultants in the service at the time went to the maximum of the scale.

Deputy Róisín Shortall: What is the maximum of each of the scales under the different contracts?

Mr. Liam Woods: My information is on what has been implemented, as the Secretary General pointed out that not everything has been implemented. For type A, as implemented to date, the maximum is €226,000. For type B, the maximum is €116,000. For type B*, it is €89,000. If fully implemented, the figures would be higher.



Deputy Róisín Shortall: Will Mr. Woods clarify that point?

Mr. Liam Woods: An increase due in the middle of this year has not been paid.



Professor Brendan Drumm: Regarding the hundreds of consultants, Deputy Shortall is correct in that we must deal with this situation. However, as has been stated, we are in a position to identify these issues. We would not like to suggest the figure amounts to a majority of consultants, since we believe it will be hundreds and not thousands.

Deputy Róisín Shortall: It is hundreds out of just over 2,000.

Professor Brendan Drumm: Some 2,500.



Deputy Róisín Shortall:   It is a large number and percentage.

Professor Brendan Drumm: Yes. This must be always aligned with the HealthStat process. The Chairman is concerned about waiting lists for orthopaedic services in County Cork. When that is lined up with the HealthStat process and the figures on the split that we will provide, it will become obvious that it is not all about numbers. Rather, it is about activity on the public side. We know what occurs when this is not taken on. For example, Sligo saw orthopaedic waiting lists of years. The period has since fallen to six months because the consultants have become involved and brought a focus to the matter. We are at the early stages.



Chairman:   It is not only that. It is also due to the introduction of the National Treatment Purchase Fund. Some of the consultants are getting paid on the double.

Professor Brendan Drumm: Any perverse incentives need to be taken out of the system.



Chairman:   They do.

Deputy Róisín Shortall:   Given the complete failure of the Department and the health boards to supervise the previous contract, it is incredible that adequate supervisory systems are not in place.



Professor Brendan Drumm: They are. As we have explained, a process must be followed. Consultants have been written to, but they need six months to bring it back on-line. The money must be then repaid. We have focused on this matter.

Deputy Róisín Shortall:   At our previous meeting, I did not get the impression that either the HSE or the Department was serious about supervising the contract. The consultants clearly have not got the message about the HSE or the Department being serious.

Professor Brendan Drumm: The message has gone out.

Deputy Róisín Shortall:   If hundreds are not adhering to their contracts, it is clearly the case that they have not got the message.



Mr. Barry O'Brien: The public-private element is only one part of the consultants' contract. Speaking as someone who was responsible for the contract's implementation and who took a lead role in the verification process, I assure the Deputy that every consultant is working 37 hours per week and has given four additional clinical hours. Where there are additional hours, work schedules have been signed off on by consultants and hospital managers. All consultants are working in teams and reporting to clinical directors. These are fundamental elements of the contract in which there is full compliance to the public's advantage.

Deputy Róisín Shortall:   I appreciate that and I will get to that matter in a moment. In terms of the mix, that so many consultants are not keeping to their contracts is disappointing. Mr.

O'Brien mentioned four extra hours, but the old contract officially provided for 39 hours. There was not even agreement on that and the consultants worked only 33 hours. Even with an extra four hours, it is still a short week.

Deputy Broughan asked a question and I am surprised that a reply is not readily available. Will the delegates provide the committee with this year's total pay bill for consultants?



Mr. Michael Scanlan: I will. I might have misled the Deputy when I said that one could correctly add last year's arrears. They are actually a part of this year's €5 million. The amount is €50 million plus €5 million, but I will get the consultants' pay bill for the Deputy.

Deputy Róisín Shortall:   Could somebody get that for us in the next 30 minutes? I am surprised that the figure is not to hand. Given the pressure on the public finances, what steps are being taken this year to reduce the pay bill? Consultants have spoken on the airwaves about taking a hit this year.



Mr. Michael Scanlan: I am not clear. Is the Deputy referring to the consultants' pay bill or to the overall pay bill?

Deputy Róisín Shortall:   The consultants' pay bill.



Mr. Michael Scanlan: Why would I be taking steps to reduce that bill *per se*?

Deputy Róisín Shortall:   What about the 8% reduction in fees decided by the Government?

Mr. Michael Scanlan: The consultants would have been subject to the pension levy.

Deputy Róisín Shortall:   As are all other public sector workers.

Mr. Michael Scanlan: They are salaried employees. This is the pay bill. I pay the pension levy, as do Members.

Deputy Róisín Shortall:   Apart from that, has there been a reduction of 8% in their fees?

Mr. Michael Scanlan: That relates to fee-paid professionals. The HSE does not employ-----

Deputy Róisín Shortall:   There has not been a reduction.



Mr. Michael Scanlan: I apologise, but to which fees is the Deputy referring?

Deputy Róisín Shortall:   Salaries.



Mr. Michael Scanlan: The pension levy.

Deputy Róisín Shortall:   Is that the only cut?

Mr. Michael Scanlan: Are there any other salaried employees-----

Deputy Róisín Shortall:   I am asking whether that is the only cut taken by consultants this year.

Mr. Michael Scanlan: I am not clear. A pension levy was applied to public servants on salaries. We applied the 8% reduction in fees to some groups of non-salaried employees who we pay on a fee basis. The consultants are paid on a public salary basis.

Deputy Róisín Shortall:   Is that the only reduction in their income this year?



Deputy Seán Fleming:   Do not forget the income levy.

Deputy Róisín Shortall:   Apart from the levies.

Mr. Michael Scanlan: That would not have been specific.

Deputy Róisín Shortall:   It is a “Yes” or “No” answer.

Mr. Michael Scanlan: Not that I am aware of.



Deputy Róisín Shortall:   That is fine. Regarding the contract’s specifics, does the 70:30 split relate only to specific patient contact hours?

Professor Brendan Drumm: This matter arose earlier and we will provide the report. The split is a complicated method of assessing patients’ complexity and takes into account the individual patient and the number of patients. It uses a case mix analysis to determine complexity. It is not simply a matter of counting patients to see who is private and who is public.



Deputy Thomas P. Broughan:   Is it a weighting of each patient.

Professor Brendan Drumm: Exactly. Otherwise, the system could be manipulated, in that relatively high numbers of low-charge patients could be seen on the private side. The method mitigates against that manipulation.



Mr. John Hennessy: To date, the measurement of activity was simply a count of patients going through the system. This was argued to be unfair, in that it did not take a full account of the levels of complexity of particular cases. What was agreed as part of the negotiation of the new contract was a weighted system of counting activities. This is done by a complicated scientific process. The ESRI does it through data as part of the case mix adjustment. The activity of consultant A may come out at 120 per 100 patients and 90 out of 100 patients for consultant B when taking account of the complexity of the activity. It is a fairer way of measuring throughput and the complexity of cases.

Deputy Róisín Shortall:   Does complexity equate to monetary value?



Mr. John Hennessy: It can but it probably relates more to time spent with the case. The more complex cases require more input of consultant time.

Deputy Róisín Shortall:   Working from memory, in the previous contracts there was an allowance of 11 hours per week for research work. Do those 37 hours refer to patient contact hours?

Mr. Barry O'Brien: The figure of 37 hours refers to clinical work. That is set out in the scheduling of each consultant. Each consultant has an individual work schedule attached to his or her file.

Deputy Róisín Shortall:   Is no other activity allowed under the contract within those hours?

Mr. Barry O'Brien: No, it refers to clinical work.

Deputy Róisín Shortall:   Can someone tell me what are the pension provisions?



Mr. Barry O'Brien: To clarify what I mean by clinical work, if one is involved in teaching or training that is still in the clinical area.

Deputy Róisín Shortall:   I did not realise that.



Mr. John Hennessy: Some other services such as clinical audit, participation in risk committees and infection control may be included.



Professor Brendan Drumm: These are MRSA-type committees.

Mr. John Hennessy: It means that this amounts to 37 hours of on-site presence by the consultant under the new contract.

Deputy Róisín Shortall:   What allowance is there for teaching?

Mr. John Hennessy: That differs between consultants. Some consultants have formal academic components as part of their contract. Others do not but the job entails a teaching component, particularly for junior hospital staff. That is part of the consultants' commitment within the figure of 37 hours.

Deputy Róisín Shortall:   Did witnesses give a commitment earlier to provide us with further information on this? Perhaps the witnesses can provide us with details on this.

Chairman:   Other work now appears to be a significant element of the 37 hours. Perhaps we can get greater detail on this. The impression we got was that the 37 hours was solely for treating patients. Now we are being told that 37 hours is a combination of direct contact with patients, research and teaching.

Mr. John Hennessy: Research is not part of a typical consultant contract.

Chairman:   Is administration included?

Mr. John Hennessy: Administration is included.

Professor Brendan Drumm: A clinic involving 20 to 25 patients amounts to the same number of letters. Administration time must be provided for and infection control committees are essential to the hospital. This varies and there is no standard template.

Chairman:   The Deputy is not passing judgment, she is seeking information.



Professor Brendan Drumm: We can show the committee the template that has been used but it will vary for every consultant.

Deputy Róisín Shortall:   Are those activities monitored and supervised?

Mr. John Hennessy: It will be very difficult to sum this up and provide the complete picture. The scheduled commitment for each consultant is available in every hospital. That is the subject of negotiation between the hospital manager and the consultant. It specifies the weekly activity of the consultant, which varies from ward rounds and outpatient clinics to theatre lists and includes elements of administration such as letter writing.

Professor Brendan Drumm: We see our internal audit function as having a significant role in assuring compliance with the schedules outlined. We have faced challenges because our internal audit process was historically very financially focussed and there was not much clinical expertise. We faced union problems where we had agreement with nurses to work within our internal audit function. We are appearing before the Labour Relations Commission soon in respect of this. If we can build up our clinical capacity in the internal audit function, there can be more assurance that the schedules, which are variable, are being monitored and delivered upon.



Mr. John Hennessy: Under the new contract, the role of clinical director includes overseeing scheduled commitment and performance of consultants and whole specialties within units. This helps to focus on where particular problems are, such as access issues and outpatient waiting time problems. It is not just a case of consultants deciding by themselves. An influencing factor comes from the clinical directorate and the hospital management system.

Deputy Róisín Shortall:   Can someone provide information on pension provision for the different types of contracts?

Mr. Liam Woods: They are the same as the pension provisions that apply generally in the public service. The individual pays a 6.5% charge.

Chairman:   Does Deputies Shortall wish to pursue this line of inquiry?

Deputy Róisín Shortall:   No.

Chairman:   Is there an element of added years in pension provision?



Mr. Liam Woods: For consultants, because of training commitments, there could be an issue of added years.



Chairman:   What is that?

Mr. Liam Woods: From memory, it is up to a maximum of seven years. I must double check that figure.



Mr. Barry O'Brien: A number of consultants in the mental health services also have enhanced pension provision specific to mental health legislation. This is similar to other people working in that specific area. This applies to consultant psychiatrists.

Professor Brendan Drumm: I do not think I have ever been accused of defending consultants to too great an extent but there is an issue in respect of added years. We want our cardiac surgeons to be trained in Canada, the United States or the United Kingdom because of throughput in some specialties. If there is not a provision for added years there is an incentive for these people to stay in the training system in Ireland, which may not be ideal for the Irish public. When they remain and when they do not may have to be examined. Certain issues, in terms of service provision, are important so that we do not disincentivise people from working in systems that bring back much learning capacity to our system.

Deputy Róisín Shortall:   Perhaps the delegation can supply details on this point. I thought consultant pension provision was the same as that of the public service but obviously there are exceptions and the arrangement is enhanced.

Chairman:   It is an add-on that is done at the very start. The most recent examples are of people negotiating added years when they are walking out the door. However, this is a standard provision in the public service.

Mr. Michael Scanlan: In public service pension schemes there are provisions for added years for professionals. Mr. Woods is correct in that it may be the normal one that applies to consultants. Whatever applies to consultants as a standard provision is designed to reflect the points that Professor Drumm made. We can provide details on this.

Deputy Róisín Shortall:   Regarding supervision of the contracts, have all the clinical directors been appointed at this stage?

Professor Brendan Drumm: At this stage we have practically all of them. The Secretary General referred to the fact that we proceeded with caution in appointing clinical directors because we wanted to have absolute agreement on what is defined as the role of a clinical director, not just what is in the contract. The model of clinical director is unique and focuses on the patient's journey. It does not focus separately on the clinical director for anaesthesia and the clinical director for surgery, where each spends time arguing with the other. This model focuses on the patient from the accident and emergency unit through to the other end. We have signed up

and there is major support from the postgraduate colleges. The last area to be filled was the north east. I believe the clinical directors are all in place.

Deputy Róisín Shortall:   How many are there?

Mr. Barry O'Brien: There are 49 clinical directors, 35 of whom are in our acute hospital system and 14 are specific to the mental health system.

Deputy Róisín Shortall:   Are they all consultants?

Mr. Barry O'Brien: They are all consultants who availed of the new contract.

Deputy Róisín Shortall:   Are they all on the new contract?



Mr. Barry O'Brien: Yes, they are on type A, B or B* contracts.

Deputy Róisín Shortall:   Is the payment €50,000?

Mr. Barry O'Brien: It is.



Deputy Róisín Shortall:   What percentage of their week is devoted to that?

Mr. Barry O'Brien: One is a clinical director at all times; it is not a case of being a clinical director for X number of hours or for X portion of the day. That is the clear executive role of a clinical director. One is appointed a clinical director and a specific job profile is attached to the contract. There is a decision-making responsibility in that role which is carried out at all times one is on duty.

Deputy Róisín Shortall:   Does that mean they do not do clinical work?

Mr. Barry O'Brien: They do clinical work also.

Professor Brendan Drumm: The clinical director in St. James's Hospital or Cork University Hospital has a massive role compared to a clinical director in a smaller hospital. The hospitals themselves are making arrangements locally with the clinicians to cover for any clinical time they give up. I cannot overstate the importance of the role. It is central to tying this back into performance and sorting out waiting lists, especially in large hospitals where a huge number of clinicians are being dealt with. I would say the role is the biggest deliverable of the contract.

Deputy Róisín Shortall:   What are the reporting and supervision arrangements for those clinical directors?

Professor Brendan Drumm: The clinical director operates in a line with the hospital manager but the clinical director also has another line - there are huge issues with quality and performance - through to our national clinical directorate led by Dr. Barry White. We will roll out many chronic disease management programmes to standardise the treatment of patients with chronic

diseases and that will be done in a line from Dr. Barry White's clinical directorate to each local clinical director. There would be significant issues dealt with from our health staff process nationally which would go down that line. Their main reporting relationship is in the local hospital management system. As we move forward with the further development of our local integration - we are integrating our hospital and community services into one management structure - there is likely to be in large geographic areas a regional clinical director.

Deputy Róisín Shortall: Typically, on the basis of those figures each clinical director will supervise 50 consultants.

Professor Brendan Drumm: In some cases it will be larger and in others it will be smaller. In larger areas there will be a need for more than the existing number. In other words, we do not envisage one clinical director in Kerry or Mayo where we have existing structures. In Sligo, Leitrim or Donegal there will be one clinical director. There are probably seven or eight units in the country - Galway, Limerick, Cork, possibly Waterford and four or five of the Dublin units - where there will be a need for up to two or three more clinical directors because those units can be very large.

Deputy Róisín Shortall: To pursue a question asked by Deputy Broughan-----

Chairman: I wish to ask a question on clinical directors. Part of the 2008 contract addressed the proliferation of posts. Are the old clinical directors, who no longer work in that capacity, still getting the €50,000?

Professor Brendan Drumm: The only place that applies is in psychiatry. There was no clinical director structure in the general hospital system; every consultancy was an independent fiefdom. The Chairman is referring to psychiatry where we have 13 clinical directors under the new system because it is a very new way of working. The existing clinical directors in psychiatry had some statutory roles.

Mr. Barry O'Brien: Specific to mental health, we had 37 clinical directors who were specifically required under mental health legislation, particularly for being the designated person in charge of centres. What has emerged is that some of those had a varying type of contract; some had it for a two year period rotating among the team, some may have had it for a fixed seven year period and some were appointed for the duration of their employment. Following negotiations we introduced 14 clinical directors with the title of executive clinical director for the entirety of the mental health service. They are the only people in receipt of the €50,000 as set out in the 2008 contract.

Chairman: What about the rest of the people?

Mr. Barry O'Brien: The others?

Chairman: Are they getting paid?

Mr. Barry O'Brien: There was an arrangement, which was not for €50,000, which was specific to a number of sessions under the previous contract of 1997. Because those people retain their legal statutory responsibility they continue to attract the remuneration for that.

Chairman: Put that into English for me. Are they still getting paid the €50,000?

Mr. Barry O'Brien: No, they are not getting paid the €50,000, they are getting paid what they were always paid.

Chairman: What was that?

Deputy Thomas P. Broughan: Are they answerable to the new clinical directors?

Mr. Barry O'Brien: Yes, they are.

Chairman: What was the rate they were always being paid?

Mr. Barry O'Brien: It was two additional sessions for the work being carried out.

Chairman: In financial terms.

Mr. Barry O'Brien: Relative to the new contract, it is approximately €42,000.

Chairman: So they retained almost €50,000 even though they are not acting as clinical directors.

Mr. Barry O'Brien: There is significant Government policy on the development of mental health and moving to mainstream the whole mental health service. Certainly, the role of the executive clinical director, considering there are only 14, is far more expansive. An executive clinical director might cover a couple of counties.

Chairman: I know that, but why are 23 people who are not doing the job getting paid €42,000?

Mr. Barry O'Brien: That is not absolutely correct because they are still carrying out the legal requirement under mental health legislation which names them as the persons with responsibility for designated centres, and that is in law. They are still being paid the agreed rate of pay for that job.

Chairman: What does their job entail?



Mr. Barry O'Brien: There are responsibilities under mental health legislation with regard to one's authority to detain people. There is the Mental Health Commission and tribunals, and dealing in that way with members of the public. It is set out quite clearly under the legislation.

Chairman: Why can the 14 not do those jobs?

Mr. Barry O'Brien: To deliver mental health services we have designated centres which were in existence and continue to be in existence as we speak.

Chairman:   Does Mr. Scanlan have information for us on that?

Mr. Michael Scanlan: I apologise but I am not up to speed on it. However, to be fair to Mr. O'Brien he is correct that it was for the purpose of the protections built into the mental health legislation, and although the title was the same they had a completely different set of functions. It is still a considerable amount of money but it is for an entirely different job; it is not a clinical director as we understood it. I can get a note for the Chairman on their functions under the Act. I do not have that information with me.

Chairman:   Does it extend into areas of the health services other than psychiatry?

Mr. Barry O'Brien: I am aware only of people having a title such as “clinical director mental health services south Lee” in Cork or “clinical director mental health services Kerry” in their employment contract. I am not aware of anybody else having an appointment.



Professor Brendan Drumm: I am not aware of it existing anywhere else other than in mental health.

Deputy Thomas P. Broughan:   Will the HSE continue to fill those posts?

Mr. Barry O'Brien: No.



Deputy Thomas P. Broughan:   They will be run down.

Mr. Barry O'Brien: Correct.



Chairman:   If they are so necessary to deal with present legislation why are they not filled when people retire?

Mr. Barry O'Brien: All of those issues will be discussed having regard for the roll-out of mental health policy, but it is not the intention to backfill any of the existing mental health directorships.

Mr. Michael Scanlan: I will get a note for the committee on this. I do not have the information with me.

Chairman:   If they are doing such an important job it seems odd that their positions are not filled when they retire.



Mr. Michael Scanlan: I understand.

Deputy Róisín Shortall:   The HSE states that clinical directors report to local hospital management. Does management then report to Mr. O'Brien or Mr. Hennessy?

Professor Brendan Drumm: We have appointed regional directors of operations in four areas.

Deputy Róisín Shortall:   How often is the data provided?



Professor Brendan Drumm: The people responsible for these areas, through which we will be fully operational with budgets from 1 January 2010, will be the regional directors of operations.

Deputy Róisín Shortall:   Monthly reports are given to the consultants on their performance.



Professor Brendan Drumm: Yes.

Deputy Róisín Shortall:   Does a six-monthly report issue?

Mr. John Hennessy: The monthly report is run automatically and is issued to each consultant. It sets out his or her public and private mix over the preceding reporting period. The report is also sent to the hospital manager and the clinical director and if problems emerge the consultant is invited by letter to a meeting to discuss them. The process for remedying problems would accord with the terms agreed in the contract. I ask the Deputy to repeat her second question.



Deputy Róisín Shortall:   Are periodic reports sent to some central place in the HSE?

Mr. John Hennessy: Yes. We accumulate the reports into a summary which shows the position of each hospital as well as the national picture.


Deputy Róisín Shortall:   How often will these reports be produced?

Mr. John Hennessy: We produce them monthly at the moment. As Professor Drumm noted, the intention is to present the next report to a board meeting of the HSE. I presume it will enter the public domain subsequently.

Professor Brendan Drumm: We can certainly forward it to the committee.



Deputy Róisín Shortall:   Will they have been published at that stage?

Mr. John Hennessy: Yes.

Deputy Róisín Shortall:   Will the names of individual consultants be included?

Mr. John Hennessy: The names of individuals are not included in the summary reports.

Professor Brendan Drumm: The Chairman has requested that information from us.

Deputy Róisín Shortall:   Is that provided as a matter of course?

Mr. John Hennessy: Not at the moment.

Deputy Róisín Shortall:   Are the reports subject to freedom of information?



Mr. John Hennessy: I do not know.



Professor Brendan Drumm: We do not need to. We will give them out.

Deputy Róisín Shortall:   Will they include the names?



Professor Brendan Drumm: No, but the Chairman has asked us for the names.

Deputy Róisín Shortall:   Has the HSE committed to providing the reports with the names?



Chairman:   No, I asked on behalf of the committee because we sought this information previously.

Deputy Róisín Shortall:   To pursue the question raised by Deputy Broughan on sanctions, what penalties are provided for in the contract?



Mr. Barry O'Brien: I shall refer again to section 20. Once the consultant and employer have agreed the total fee income, an amount of private fee income *pro rata* to the extent to which the consultant has exceeded the specific ratio will be identified. Should the excess be 10%, for example, it is agreed that 10% will be repaid. The consultant shall be given 30 days to remit this amount and will be entitled to resume private practice on receipt of confirmation of the repayment. Should the consultant fail to submit the amount, he or she will not be allowed to resume private practice in respect of the cohort of practice where he or she is in excess of the agreed ratio.

Deputy Róisín Shortall:   What happens if he or she continues to do that?



Mr. Barry O'Brien: As I advised the committee, we have put in place a robust human resources process to take whatever action is deemed appropriate, in consultation with people such as the clinical director and the hospital manager. It must be acknowledged this would occur at the end of a process lasting nine months and it would have been flagged to the consultant that an issue had arisen in respect of constant breaches of the agreed public-private ratio.

Deputy Róisín Shortall:   Mr. Scanlan said that the key issue was measuring waiting times for access. A recent report by the Comptroller and Auditor General on waiting times criticised the system for having dysfunctional practices in the management of waiting lists. It called for a ban on closing outpatient appointment books in order to bring waiting times under control. I completely agree that managing waiting times is key but the report indicated that little or no progress has been made in improving outpatient waiting times. Indeed, it is difficult to find data in that regard. What is being done about this?



Professor Brendan Drumm: We publish outpatient waiting times for every hospital in the country on the Internet through our HealthStat programme.

Deputy Róisín Shortall:   That is only a recent development.



Professor Brendan Drumm: It has been operational for over a year. We collated outpatient waiting times and published them on the Internet.

Deputy Róisín Shortall:   What is being done about improving these times?

Mr. Michael Scanlan: In fairness, it is an issue in respect of which the system should be put under pressure. The first step is measurement, which creates its own pressures. Every year we hold discussions with the HSE in the context of the service plan. Professor Drumm can correct me if I am wrong, but I understand it is not only a case of measurement but also specific actions such as reducing the number of returns and increasing the proportion of new visits. In terms of using existing capacity, we try to reduce the time taken to access services. The do not attend rate was also targeted. I would be the first to admit that we have to do more, however, because that is where legitimate questions may be asked about the health service.



Deputy Róisín Shortall:   The issue is not whether more needs to be done or whether the present arrangements are acceptable. They clearly are not acceptable. The waiting time for an outpatient orthopaedic appointment is 461 days. God knows how long one must wait for the actual procedure. My question is what the HSE is doing about this.

Professor Brendan Drumm: We started by measuring the extent of the issue for the first time. We only sought this information in order to fix the problem. We could have buried the information because nobody had ever asked for it. It is a credit to the HSE that we have taken the initiative to publish it ourselves.



Deputy Róisín Shortall:   I do not think it is true to say nobody ever asked for the information.

Professor Brendan Drumm: No one asked for it.

Deputy Róisín Shortall:   Public representatives have frequently raised the problem.



Chairman:   The information was sought but it was unavailable.

Professor Brendan Drumm: Information on outpatient waiting lists was never available.

Deputy Róisín Shortall:   Umpteen politicians have requested waiting lists.

Professor Brendan Drumm: We have put the information on the Internet. We are investigating the number of outpatients seen per full-time consultant and over the coming months we will be able to set the best performing outpatient consultant activity as the bar for the number of new patients seen. Return visits and do not attend rates can then be managed. The data is not yet complete but we are beginning to see significant variations in the numbers of patients seen by consultants. Unfortunately, the data does not closely accord with the numbers appointed. Where we have more people, we often see less activity. We are focusing at present on dermatology,



orthopaedics and ear, nose and throat. We are seeking to appoint clinical leaders in each of these areas to bring a focus to the management of waiting lists. Significant effort is being invested on the ground in terms of bringing measurements to each clinical director and asking, for example, why each of his or her consultants is only seeing five new orthopaedic patients per week when 25 are seen down the road. This is the measurement issue and these are the figures which are driving the significant changes we are beginning to see.

Deputy Róisín Shortall:   Are numbers of patients seen per consultant not included in the new contract?

Professor Brendan Drumm: At the end of the day, the total number of new patients seen is not part of the new contract.

Deputy Róisín Shortall:   Those are two different answers.

Professor Brendan Drumm: No, the split between public and private is 80:20. If I see five patients and four are public, I could be compliant. One cannot include that level of detail in a contract. We manage that through a local management system.

Deputy Róisín Shortall:   I presume there is a provision in the contract for dealing with productivity.

Mr. John Hennessy: Perhaps I could help with that.

Professor Brendan Drumm: There is in terms of coming to work and us driving performance.



Deputy Róisín Shortall:   Is that just turning into work?

Professor Brendan Drumm: No, it refers to us driving performance, which we do in a big way.



Mr. John Hennessy: The measurement side of it is a significant factor in making explicit what needs to be done and where the waiting problems are. The contract, as has been mentioned by others, is one of the tools available to address problems like that. In particular, it is pertinent to the role of a clinical director. My experience of clinical directors on the ground is that they are becoming actively involved in service delivery and access problems. That is about getting into the detail of the problem with individual consultants and specialist areas and addressing it.

The contract does not explicitly state that waiting times need to be addressed in a particular area but it provides the tools in the form of a clinical director role to address the problems.



Professor Brendan Drumm: The ultimate way to manage the issue once the bar is set is to say that if, for example, an orthopaedic patient is waiting longer than six months for an outpatient appointment in Cork, through an internal process, we have the patient seen in Waterford. We charge that back to Cork. The ultimate solution is that when we have the figures we set a point beyond which patients cannot wait and we will have them seen elsewhere in our system where there is capacity. That will be charged back.

Chairman:   That is not correct. I know from personal experience that patients in Cork cannot even get on the waiting list for outpatient appointments. I have evidence of that.



Professor Brendan Drumm: That is certainly unacceptable.

Chairman:   They cannot get on a waiting list and are told they will be communicated with by the consultant general, whoever that is. Is that a new post? It is in the terminology used by the CUH in Cork. The people are told that the consultant general will at a future date arrange an outpatient appointment. They cannot even get on a list.


Professor Brendan Drumm: We have an extremely effective clinical director, Dr. Richard Greene, in Cork University Hospital.

Chairman:   I am not doubting that. I am just saying that people cannot get on a list.



Professor Brendan Drumm: He has, along with us and our HealthStat process, had a very definite interaction with the problems of that area in Cork. It is within our focus and we must manage that. I do not understand how people are not even getting on a list and I will have to check it.

Chairman:   I can give the documentation proving it.



Professor Brendan Drumm: I do not doubt what the Chairman says but it should not be happening. Ultimately, the way to manage the issue is through the HealthStat process. If a patient goes beyond a waiting time he or she should be dealt with elsewhere in the system with the cost applying to the first hospital.

Chairman:   Are people who cannot get on the list part of the statistics?



Professor Brendan Drumm: No, absolutely not.

Chairman:   That is how they are massaged.

Professor Brendan Drumm: It is pretty unusual that somebody cannot get on a list. That is why I want to see the data.

Chairman:   I will show them to you. I also put down a Dáil question on the matter.

Professor Brendan Drumm: To be fair to most of the system, it is not typical.

Deputy Róisín Shortall:   I do not have time to go into private patient income but the point should be made on the issue and on the supervision of consultants, value for money for taxpayers etc. All of these issues would be dealt with if there was a single tier health system that was insurance based. I will leave it at that.

Chairman: Before I go back to Deputy Fleming I wish to come back to an issue raised earlier regarding added-on years. I mistakenly said that it was decided at the start of the contract. With regard to the new type B or C contracts, or the old category 2 contracts, may people on those contracts change to the higher type A or category 1 just a few short years before retiring, which will result in improved pension and an enhanced lump sum?

Mr. Barry O'Brien: To clarify that, the consultant contract in 2008 was offered to all existing permanent consultants at the time. There was potential for people on old category 1 or 2 contracts etc. to opt for a contract type A or B. Those in category 2 could go to type B* or A as well.

Under contract 2008, it cannot be done. One must make a formal application to change contract type and there is a procedure for doing so. The employer has a critical input into deciding whether any change of contracts will be allowed. As part of the contract, there was a dedicated process whereby in excess of approximately 120 consultants sought a change in category under an agreed appeals process, with 70% of those refused. We already have a procedure for dealing with consultants who seek a change of category.

Chairman: Is there is a mechanism in place with agreement?

Mr. Barry O'Brien: No. It was offered to every permanent contract holder so the Chairman may be able to instance somebody who was within a year of retirement who changed from a type B or B* contract to a type A contract. That person would have been entitled to do so under the offering of the contract. If a person has now taken a type B or B*, he or she cannot just write to the employer just because he or she is retiring in six months and seek to take a type A contract to get to the higher rate of pay to improve pension benefit. That cannot be done.

There is an agreed procedure in the contract and a period must elapse prior to any consultant even being in a position to seek a change in category. There is a procedure to be followed and the employer will be in the position to have the ultimate say on whether it is in the public interest. Why would that employer change somebody from type B* to A?

Chairman: What is the minimum time involved?

Mr. Barry O'Brien: It is two years.

Chairman: There is a procedure in place where a person can upgrade.

Mr. Barry O'Brien: A person may apply to be upgraded.

Professor Brendan Drumm: The fundamental issue in these proposals and reviews is whether they are in the public interest.

Deputy Róisín Shortall: Who decides that?



Professor Brendan Drumm: The committee contains several members of the public, for example.

Deputy Róisín Shortall:   What is that committee?



Mr. Barry O'Brien: There is a consultant applications appointments committee, which has representatives of all the stakeholders, including members of the public. It has already met once and deals with applications. It makes recommendations to the HSE on the correct categories. For example, if a cardiologist is required, the committee would look at a proposal and would be able to make a recommendation.

Deputy Róisín Shortall:   Does the committee deal with pension requests?

Mr. Barry O'Brien: No.

Deputy Róisín Shortall:   It deals with requests to switch categories, which would have pension implications.

Professor Brendan Drumm: It is very clear in the context. The Comptroller and Auditor General or anybody else could come in to see the justification. Once it is in the context of the public interest, the committee would have to be able to stand over it. There was wholesale movement of people in the previous contract so it was on our radar when we negotiated the contract. We were looking to protect against it.

Chairman:   I do not understand this committee with members of the public on it. I have never heard of it.

Professor Brendan Drumm: It is a consultant appointments committee. It is analogous to the old Comhairle na nOspidéal; that had statutory authority but this does not. It reviewed all applications for consultants to see if they fitted into a national plan in terms of how services would be delivered. There was an agreement that a committee would be set up to review consultant posts in order to have expert input into whether a proposal was reasonable. In other words, if a proposal sought to start a consultant service in Kerry General Hospital to which there was no logic, the committee would have the expertise to say it was not a reasonable application.

On that committee there is significant representation - I do not have a list of the full membership with me - of the public interest in terms of patient representatives etc. It is a non-statutory function.

Chairman:   May we have details of that?

Professor Brendan Drumm: We will give details of membership etc.

Mr. Michael Scanlan: Before we move on, I have figures on the consultant pay bill. The figures are for this year and the total pay bill figure is €535 million. That includes €483 million,

which seems to be the basic salary cost, and another €2 million consisting of these on-call and call-out payments.

Deputy Róisín Shortall: From where did the figure of 350 come?

Mr. Michael Scanlan: That was for 2006.

Deputy Róisín Shortall: The 2006 figure.

Mr. Michael Scanlan: The other information I got on the private health insurance market suggests that so far the fall in the numbers in private health insurance market has been very small, some 1%, perhaps 12,000 or 22,000. The Deputy who referred to that matter has since left. The figure depends on what it was measured from, but it was about 22,000 from December to June. I do not have the latest figures with me.

Deputy Róisín Shortall: Can Mr. Scanlan clarify what is happening in respect of the figure of €2 million?

Mr. Michael Scanlan: Which figure?

Deputy Róisín Shortall: Mr. Scanlan said €483 million is the basic pay bill.

Mr. Michael Scanlan: The figure of €2 million is in respect of what are called B and C factor payments in the consultant contract. Essentially, they are for on-call and call-out payments. Having completed one's 37 hours per week, if one is on call and called in for emergency or other work one gets a call-out payment, although I believe such payments are capped.

Mr. John Hennessy: Yes.

Deputy Róisín Shortall: However, they could be included in the basic cost.

Mr. Michael Scanlan: They are part of the pay bill.

Deputy Róisín Shortall: It is a recurring cost.

Mr. Michael Scanlan: Absolutely.

Deputy Róisín Shortall: Therefore, €35 million is the pay bill.

Mr. Michael Scanlan: Yes.

Deputy Thomas P. Broughan: Can Mr. Scanlan indicate what is the additional cost of bringing in the new contract? In other words, what is the additional cost of it to the public purse?

Mr. Michael Scanlan: The figure that we had to provide this year was €5 million.

Mr. Liam Woods: It is approximately that. I had a figure, and we will confirm it for the Deputy, of €86 million for that. It is around that figure, and presumably that would be included in the €35 million.

Deputy Seán Fleming: I want to follow up on a point made by the Chairman and advise Professor Drumm that it is a regular occurrence that people cannot get an appointment to get on a waiting list for orthopaedic services in the midland region. That is the normal query that is raised with me in my constituency office. They cannot get an appointment to even get onto the list. That leads to a situation in orthopaedic units where many service plan procedures are carried out in the first nine or ten months of the year. The theatres and the staff are essentially being paid, the overheads are being incurred but the required staff may not be available to man the theatres. There is a great deal of underutilisation of staff and senior personnel towards the end of the year where, say, a hospital indicates the number of hip operations it has budgeted for the year and that it had reached that figure on 1 November. There is a major underutilisation in some of those facilities. That is a general observation. I support what the Chairman said. We find that this is a regular occurrence at this stage.

On the matter of the consultants' contract, I want to tease out the costs. Can the representatives indicate the categories of extra payments or allowances for, say, the category A consultant? Mr. Scanlan mentioned that the salary rate goes up to €226,000. That can include five hours weekend work but there must be extra payments for weekend cover, overtime or other allowances. How many categories of other payments can such consultants get on top of their salary of €226,000?

Mr. Michael Scanlan: I am aware of the B and C factor payments. I mentioned those, which apply if, as the Deputy said, a consultant is called in on a Saturday or a Sunday. I do not have those rates of payment with me.

Deputy Seán Fleming: If they are not easily available, Mr. Scanlan might forward them to us.

Mr. John Hennessy: The B and C factor payments are call out allowances.

Deputy Thomas P. Broughan took the Chair.



Deputy Seán Fleming: I am talking about the type A consultant who is on the basic consultant's salary, works exclusively in a public hospital and is solely remunerated by way of salary. What further payments can a type A consultant receive?

Mr. John Hennessy: That would include type A consultants. If their duties required them to be on call to cover general take-up and if they were called in at night for an emergency, their contract includes a provision for a B or C call out.



Deputy Seán Fleming: What does a B or C call out mean? I am talking about a consultant type B.

Mr. John Hennessy: It depends on the time, whether it is daytime or nighttime.



Mr. Liam Woods: They are called B and C, it is not related to the contract name for the consultant contract.

Deputy Seán Fleming:   Mr. Woods can understand why I asked that question.

Mr. Liam Woods: No, it is an old naming convention.



Deputy Seán Fleming:   The representatives might indicate the highest amount paid over and above a consultant's basic salary.

Professor Brendan Drumm: It could be a clinical-----

Deputy Seán Fleming:   We have mentioned that already. That was my first question and the representatives can come back to me with that information.

My second question relates to a point that is covered in the Comptroller and Auditor General's report. In the case of a consultant on the B contract who has a salary of €216,000, does that salary cover the 37 hours per week or if the consultant has a public-private case mix of 70:30, does that salary cover 70% of the 37 hours per week? If such a consultant was working the full 37 hours, he or she would have an annualised salary of more than €300,000. The representatives might talk me through that procedure in order that I can understand it. Does a salary of €216,000 apply to a category B consultant who is required to spend only 70% of his time in public practice and who can spend 30% of his time in private practice? Is that €216,000 in respect of 70% of the 37 hours per week, or must the consultant work 37 hours per week in public practice and then he can work extra hours in private practice? The representatives might explain that.

Mr. Michael Scanlan: It is a fair question. A salary of €216,000 is paid to the individual to be present for 37 hours a week. Within that 37 hours there is a rule about the ratio of public-private patients. During that 37 hours per week, the consultant can earn extra income for doing private patient work. The Deputy is right in that respect, that the figures could be grossed up. The one slight caveat I would mention - on which Deputy Shortall touched earlier - is that it is not all down to an 80:20 or 70:30 ratio of the hours involved. As Deputy Fleming said, there were other hours involved. I recall that at one point the consultants wanted us to try to measure the 80:20 mix in terms of hours and we were told that all the administrative work was public practice, so we said "No" to that. We measured throughput, the number of patients treated. Other than that, the Deputy's core point is right. The figure does not reflect their total earnings or income for 37 hours a week.

Deputy Seán Fleming:   If a consultant was able to earn the same amount of money for the 30% of his private work during the 37 hours per week - he or she would possibly charge more in terms of his or her hourly rate - his or her grossed up salary could be of the order of €309,000.

Deputy Bernard Allen resumed the Chair.

Mr. Brendan Drumm: That would depend hugely on the specialty, having regard to the earning capacities of specialties. That is the reason there was an A and B contract. The A

contract was priced significantly higher for the 37 hours per week on the basis that anybody who took a B contract was going to have the option of making money. That is the reason a gap was put it, as it were, but depending on one's specialty, that gap might be reasonable or totally unreasonable.

Deputy Seán Fleming: In a sense, nobody here can comment on that because it is private income.

Mr. Brendan Drumm: No, but we would have a pretty good idea that it would be very variable across specialties.

Deputy Seán Fleming: We are all familiar with accident and emergency issues. Work accidents and car accidents are a regular feature of the work in accident and emergency departments every day of the week. A consultant report in respect of the injuries sustained is required in all insurance claim cases. If one is a private consultant or a consultant dealing with a private patient, one could charge several hundred euro for reports on foot of insurance claims in court cases. Can the category A consultant earn money for doing such work, when it is part of the consultant's work to be present to do the job? Can such a consultant get a top-up in terms of such private work?

I take the view that such a consultant is paid by the State to do the job while he or she is there to do it. There should be a fee chargeable by the HSE for the completion of such a report by a type A consultant, equivalent to that charged by a private consultant. Otherwise we are subsidising car insurance companies and others who are getting free reports in this respect. That thought came to mind when we were discussing accident and emergency admissions. The representatives know the point I am getting at.

Mr. Barry O'Brien: The type A consultant is allowed to meet requirements, say, for a coroner's court, in the event of writing a specific report in a case involving an insurance claim. Such consultants are allowed to do that and still be deemed to be compliant with a type A contract.

Deputy Seán Fleming: Is a report requested in a court case, involving dangerous driving which resulted in a car accident, paid for? These matters go to court regularly.

Mr. Barry O'Brien: If a fee is payable for that, the type A consultant gets that fee.

Deputy Seán Fleming: Does the consultant get that fee privately even though he or she also gets the public fee? One could not have that situation.

Mr. Barry O'Brien: It is deemed to be work outside the 37 hours and is specifically allowed for within the consultant's contract. The body of the contract identifies the specific areas where a type A consultant can do this type of work.



Deputy Seán Fleming: I am teasing out this and I am disappointed to hear this. I asked earlier about extra allowances, overtime attendance and so on. Can Mr. O'Brien give us additional information on what other type of income a type A consultant can achieve over and

above the €226,000? We come to this issue now. From a taxpayer's point of view, I cannot understand how, if a person comes into an accident and emergency department and is dealt with by a type A consultant who is being paid a public salary as a public servant, that consultant can then use the case he or she dealt with to earn income privately from an insurance company. Am I missing something?



Mr. Barry O'Brien: With the permission of the chair, I will read out the contract for the type A consultant 2008, which sets out that a type A consultant cannot engage in private practice..

Professional medical/dental practice carried out for or on behalf of the Mental Health Commission, the Coroner, other Irish statutory bodies . . . medical/dental education and training bodies shall not be regarded as private practice. In addition, the provision of expert medical/dental opinion relating to insurance claims, preparation of reports for the Courts and Court attendance shall not be regarded as private practice.

That is embodied in the contract.

Deputy Seán Fleming:   They can do court reports and such like.



Mr. Barry O'Brien: That would be viewed as external to their 37-hour week.

Deputy Seán Fleming:   Is a fee charged for that work? It would be in the case of a private consultant. Who gets the fee from the insurance company for providing a medical report in a court case?



Mr. John Hennessy: The consultant concerned would receive the fee in that instance. The expectation we would have is that such activity would not take place within the 37 hours per week commitment.

Deputy Seán Fleming:   It is an expectation.

Mr. John Hennessy: No, it is more than an expectation.



Deputy Seán Fleming:   Court cases are normally held between 8 a.m. and 8 p.m.

Mr. John Hennessy: A consultant who is scheduled to be in clinical service during the normal working day would be expected to take leave to pursue a private interest of that kind.



Deputy Seán Fleming:   Does the delegation understand my basic point about the patient involved in an accident and the consultant who is being paid to do his or her public job as a public servant? That is almost like a garda going to court and being able to charge and get money privately. The garda investigated the same accident. Accident and emergency people such as fire brigade personnel would have been there. The garda is obliged to make a report and is paid a salary to do his or her job. When the garda goes to court, having investigated the case on public time, he or she cannot put in a claim to the insurance company and get a fee of some hundred euro from the insurance company for the report. Often the garda must go to court on a day off.

Why is the medical consultant who dealt with the same person in the accident and emergency department, who is paid to deal with that case on public time and on public salary, able to bill an insurance company privately? The garda cannot do so in respect of the same accident. I ask for this to be explained. This is what emerges when we start teasing out information. I am amazed we are having this discussion but it appears necessary.



Mr. John Hennessy: We must distinguish between the writing of a report for an insurance company and the treatment of the patient. The treatment of the patient would be expected to be provided by a consultant with a Type A contract as part of his or her commitment to the public health service. If a report is required by an insurance company and is provided in the consultant's own time there is not much we can do to control that.

Deputy Seán Fleming:   I ask the Secretary General for his observations on this type of debate. Should we turn a blind eye to it?



Mr. Michael Scanlan: I do not say we should turn a blind eye to it. That is the fact and it is in the published contract. I was going to make the point that was made. I do not argue for or against it. We hire and pay the consultant primarily to treat people. As the Deputy stated, the garda has a different job. When a garda is called in on his or her day off to give evidence in court, he or she will be paid overtime for that. Regarding a consultant who does a report in his or her own time, the view taken during the talks and reflected in the contract was that he or she could keep the fee.

Deputy Seán Fleming:   Nonetheless 90% of the work of dealing with the case in hand was done while the consultant was working on the public payroll.

Mr. Michael Scanlan: The treatment was done then.

Deputy Seán Fleming:   We heard that administration in respect of cases is done as part of the 37-hour week and we accept that. When a person is seen in an outpatients department the consultant has letters to write and I accept fully this administration must be done. However, the consultant is able to do this extra work and make a charge. Does this happen?

Mr. John Hennessy: I would regard the writing of reports for insurance claims within the working time commitment of 37 hours as a breach of the contract.

Deputy Seán Fleming:   The Comptroller and Auditor General's report states that the type A contract is for consultants "who work exclusively for the public hospital and are solely remunerated by way of salary". We hear now they can have remuneration paid privately by an insurance company. This might be a small point but sometimes when one uncovers one small point there are several others of a similar nature that may not be known to us. I cannot square the Type A consultant who is to be remunerated solely by way of salary being able to earn private income as a result of dealing with a patient.

Mr. Michael Scanlan: The only further comment I will make is intended to prevent further confusion. Concerning what Mr. Barry O'Brien read out, it is important to also read that. I take the Deputy's point about what he calls private income albeit from an insurance company, but he

should be aware that according to the agreement and the contract, a type A consultant may also do what might be called other public work and get other public payment for that. A couple of other examples were mentioned. I do not want there to be a misunderstanding.

Deputy Seán Fleming: This is the first time such a statement was made to the committee, namely, that a type A consultant can now do other public work. It is in the contract and I accept what Mr. Scanlan says. He has the contract in front of him, which we do not, and he deals with it on a daily basis. It is new to me that a type A consultant can receive income from other public work. Will the delegates tell us the other kinds of income? Perhaps they might send the committee a detailed note on this. I do not wish to labour this point because I thought it was a small one but there seems to be an opportunity for a type A consultant to be remunerated through other methods as a result of his or her public work.

Mr. Barry O'Brien: Let us consider mental health. The Mental Health Commission is seen as a significant advancement in the delivery of mental health care to the public. It is accurate to say that nearly 100% of consultant psychiatrists are on the type A contract. If the legislation which established the Mental Health Commission set out appropriate fees to be paid we could have a situation where mental health legislation to protect people could become inoperable due to the fact that all consultants who are type A would not be able to attend.

This must be read in the context of the critical functions of other State agencies and how they are to be allowed function appropriately in carrying out their jobs under statute.



Deputy Seán Fleming: Essentially, the consultant who prepares the private report for the insurance company gained that information while he or she was in receipt of public dues as a type A consultant in a public hospital. It did not concern a public bed and no other public consultant was allowed near the case. I find it strange that a person can use information received while doing a public job to earn income privately.

There is an issue of principle here regarding people in the public service. I return to the notion of the garda making a report, doing his or her job yet being able to claim a nixer from the insurance company for helping to solve the case. It is the same principle. Do the delegates see how I have a difficulty? Do they understand my point? I shall leave it at that but we will return to it subsequently. We shall ask for further information. We have not read the contract as the delegates have and more information may be contained in it. I was surprised to learn this. I thought the situation was sacrosanct and the type A consultant was to be remunerated solely by public salary. We hear now that is not quite the case, so all is not as it seems. That was all I wished to query.

I refer to the matter of income from private patients. I seek confirmation about a sentence in Mr. Scanlan's opening statement. He stated the Minister has a clear policy position in respect of type A contracts to the effect that public hospitals may not raise a private accommodation charge in cases where a patient is admitted under the care of a type A consultant, nor may any other consultant involved in the treatment of such a patient charge a fee. I understand this is the position of the Department of Health and Children. Is this taking place also in respect of people who present initially to type A consultants? I understand the HSE is in control of the

accommodation, but what control mechanism is in place to implement the statement of the Secretary General, who in turn reiterated the position of the Minister? We understood this was the position already from previous meeting.



Professor Brendan Drumm: Is the question how to ensure other consultants cannot charge? Technically, it would be difficult because a form must be signed stating that a patient is a private patient. The type A consultant would have no incentive to sign such a form because he or she would receive nothing out of it. The hospital has no incentive to submit such a form because the HSE does not get anything from it. It is difficult to see how a patient could be billed by another consultant.

Deputy Seán Fleming:   The bill could come from his or her insurance company.

Professor Brendan Drumm: A form must indicate to the insurance company that a patient presented and certain procedures were carried out. I do not think a secondary consultant could submit such a form unless the insurance company came to a separate arrangement with him or her.



Deputy Seán Fleming:   How is that being implemented?

Mr. Liam Woods: The control is that the insurance company requires a primary admitting consultant to sign the form. The primary admitting consultant has no interest in the signed form.

Deputy Seán Fleming:   I have more questions but I will not be long and I have waited for some time to intervene. What happens a patient who presents to an accident and emergency department and meets a type A consultant but who wishes to go private? Such a person may arrive in the department but may have to remain in hospital for a week. What happens such persons indicate they have VHI cover when they are admitted upstairs? Can the delegation talk me through that process? I imagine many patients have paid for private VHI insurance but end up in a semi-private ward in a hospital. Is there angst among patients over this situation?

Professor Brendan Drumm: There is no need to talk the Deputy through the process. As the policy rests, one cannot be a private patient in such a situation.

Mr. John Hennessy: Such a person cannot avail of private care.

Deputy Seán Fleming:   Is the position that such a person cannot get a private room? I am simply putting the question.

Professor Brendan Drumm: If such a person were admitted on a night when a category B consultant was there, he or she could do so.

Deputy Seán Fleming:   We know that too.

Mr. Michael Scanlan: I wish to make one clarification. In an accident and emergency department, a patient cannot ask for or insist upon private treatment.

Deputy Seán Fleming: I refer to cases of admission.

Mr. Michael Scanlan: It depends on whom one meets on admission. That determines the matter.

Deputy Seán Fleming: Is it not the consultant one meets in the accident and emergency department which matters?

Mr. Michael Scanlan: That is the only clarification of which I can think.

Deputy Seán Fleming: Is it up to the patient when he or she meets a type A consultant in the accident and emergency department or when he or she is informed of the need to be admitted? What if the patient is plucky enough to request to be admitted by a type B consultant?

Professor Brendan Drumm: No, there is a rota.

Mr. Liam Woods: No.

Chairman: The Deputy should note a patient is asked whether he or she is a private or public patient in an accident and emergency department.

Mr. Michael Scanlan: I will revert to that matter presently but this is a separate question.

Deputy Seán Fleming: I understood the matter was determined by whom one met at the accident and emergency department. However, it seems it is determined on admission.

Professor Brendan Drumm: No, the accident and emergency consultant is not responsible for when a patient is admitted. There is a rota in every hospital indicating that consultant A is on-call on Monday night and consultant B on Tuesday night----

Deputy Seán Fleming: A patient would be able to find a type B consultant in most places to ensure private admission.

Professor Brendan Drumm: No, because there would only be one consultant on-call.

Deputy Seán Fleming: Okay.

Professor Brendan Drumm: A patient may be able to find a night that is appropriate.

Deputy Seán Fleming: The Chairman has reminded me of something. Last weekend, I attended an accident and emergency department with a person. It was not my local hospital. The person was asked for a PPS number and the next question was whether the person had private health insurance. That was at the admission desk before the person went to triage or before being seen by anyone. The person was asked about private health insurance at the first check-in desk last Sunday.

Mr. John Hennessy: That should not happen.

Deputy Seán Fleming: I understand it was even on the form to ask the question. I do not believe the person was asking the question for the craic.

Professor Brendan Drumm: Historically, it may have been done on the basis that if someone was admitted, the data would be collected. However, the Deputy is correct. We have issued instructions on the system. It should only be in respect of admitted patients.

Chairman: Professor Drumm should note that we heard that two years ago but it is still taking place. That issue was raised here two years ago.

Deputy Seán Fleming: I encountered such a situation personally on Sunday afternoon last.

Professor Brendan Drumm: That should not happen. We have no need to know-----

Chairman: Should a directive go to all hospitals?

Professor Brendan Drumm: It has gone to all hospitals. However, we will take up the matter again. A patient should not be asked. There would be a need to ask if a patient is admitted.

Deputy Seán Fleming: I understand that.

Professor Brendan Drumm: The Deputy is correct. In addition a patient should not be asked when presenting for or requesting a diagnostic test such as an X-ray.

Deputy Seán Fleming: However, it is still happening. There is a breakdown.

Professor Brendan Drumm: The chairman raised the issue of the refusal of an appointment.

Deputy Seán Fleming: I am not referring to a refusal, but to not being able to get it.

Professor Brendan Drumm: Irrespective of how far out the times are, anyone who sends in a request for an appointment is absolutely entitled to do so. If this is not being provided there is a great risk for everyone involved, including the consultant.

Deputy Seán Fleming: I refer to the discussion we held at the last meeting about the loss of income and the €20 million and €50 million. To close off the matter, it appears when a person is admitted by a type A consultant, the details of private insurance are not taken. Logically, I believe there would be a loss. My gut instinct and that of the HSE leads me to believe as much, but we will no longer capture the information. We are not able to measure the potential loss. If we do not seek the information from people as to whether they have private insurance – whether VHI or Quinn – we will never be able to measure it. That is where this matter is headed. Our gut instinct tells us there is definitely a loss. We will never be able to prove it because we do not

have a mechanism to capture it. I believe that is where this matter will be left, based on the discussion today.

I refer to two final points. Reference was made to the ratio of public to private beds. Will the HSE inform the committee of the overall number of beds in the country, between public and private beds in public hospitals, and the private hospitals not under the control of the HSE, such as the Mater Private Hospital, Blackrock hospital and the private hospital in Galway. How many private beds are there? In terms of hospital beds in Ireland today how many are public and how many are private? The HSE may not know the answer but the Department of Health and Children should know.

Professor Brendan Drumm: We have figures from our bed review carried out some years ago. They date from two and a half years ago. We could produce that figure. As I recall at that stage there were approximately 2,000 private beds but the figure may be significantly higher than that now. However, we can provide that figure.

Deputy Seán Fleming: I seek the most up-to-date figure. It should be easily obtained because there are a distinct number of private hospitals in the country. In the debate we have become hung up on the mix of who is presenting. Many people go for elective surgery strictly in private hospitals all the time. They are part of the population and this has not come under our remit.

I refer to the matter of the amount of money on which the HSE awaits payment from private health insurance companies. Does it boil down to the fact that private health insurance companies will not pay accommodation costs to the HSE until the clinical services bill is received? Why does the HSE not simply sit down and explain that it is a big player? A chapter has been published in the annual report of the Comptroller and Auditor General on this matter solely because the HSE has not been in a position to submit accommodation bills as soon as they are ready. Consultants are holding up the process. This is happening because the private sector, including VHI and Quinn Insurance, will not pay the HSE for accommodation costs without the accompanying clinical services bill. What if the private health insurance companies paid accommodation costs separately?

We have all encountered cases in which people have been in private hospitals. A bill may arrive two months later paid by the private health insurance company, but the anaesthetist's bill may not have arrived on time. The insurance companies are able to pay when it suits them to pay a clinical service bill much later and separately from the original accommodation costs. Why can the HSE not do that? If the HSE were able to do that with private health insurance companies there would not be such a chapter in the report. The companies would pay the HSE for accommodation costs as quickly as the bill was submitted. I am sympathetic to the position of the HSE and I do not believe it should be in this position on this issue.

Mr. Liam Woods: It is our intention to move to a stage where we get paid for accommodation quickly. We understand the notion that insurers may need other information about the nature of a clinical condition and consultant sign-off but we do not maintain it is necessary for that to be tied in to us receiving payment for accommodation. When I referred earlier to centralisation and the

work we are currently doing with insurance companies, it is also with a view to shortening our payment period to 30 days, which is down from 180 or 190 days. One way to do that is to disconnect the two components.

Deputy Seán Fleming: Where is the blockage to that happening immediately? Is it in the delegation's system or is it the case that the private health insurance companies do not want to do it because it is a way of delaying payment?

Mr. Liam Woods: Within the current process, our delay is in the signing of forms.

Deputy Seán Fleming: Where is the blockage?

Mr. Liam Woods: Beyond the current process, we need to negotiate or agree a position-----

Deputy Seán Fleming: Are they refusing to pay for accommodation only?

Mr. Liam Woods: We have found that in terms of the work we are doing with them recently, particularly the major ones, they are co-operative in terms of moving towards accelerating our cashflow.

Deputy Seán Fleming: Could we be a little harsh on the delegation by saying it has not moved to get its accommodation bills before now? I know there would be a matching down the road.

Mr. Liam Woods: We would need to change the current process.

Deputy Seán Fleming: Internally.

Mr. Liam Woods: We can do that unilaterally. A small amount could be done internally but we could submit bills for accommodation unilaterally.

Deputy Seán Fleming: For the delegation to do that would be the essence of the outcome of this chapter. We had a full chapter on the delegation not getting paid for six months. Let the private consultants worry about getting their bills paid in due course. It is not the delegation's problem or our problem. It is their problem.

Mr. Liam Woods: That is exactly where we want to get to.

Deputy Seán Fleming: Is that the solution to this issue?

Mr. Liam Woods: Yes, on the payment side. We want a bill for accommodation to go straight through and be paid within 30 days, which is the normal term for business.

Mr. Michael Scanlan: We had discussions with one or other of the private health insurance companies, particularly when the Minister met the VHI regarding payments of €50 million. The Deputy may be correct about the solution but in fairness to Mr. Woods I am not sure if the



solution is entirely in his hands because my understanding from the VHI is that its turnaround time from receipt of bill to payment is a matter of days. It also said its system of linking accommodation and consultant is used in private as well as public hospitals. It naturally asked the question on why it differed. Another thing it said, which is something with which we may be able to help, is that what determines private status in the public system is one's treatment payment to one's consultant, which is the phrase used in the Comptroller and Auditor General's report. It would need to be sure that the patient in question was a private patient. The core of the Deputy's suggestion is probably correct.



Mr. Liam Woods: There is another potential there. As Mr. Scanlan rightly reflected, there are duties on insurance undertakings, but given that we know 97% of our income is collected we could simply seek the cash and adjust it retrospectively based on billing.

Professor Brendan Drumm: We need to be clear. When Mr. Scanlan refers to the difference between public and private, there is very a straightforward difference.

Deputy Seán Fleming:   It is business.

Professor Brendan Drumm: A private hospital will tell a consultant, "Unless we have all your forms in this week you will not be working here next week". The levers for getting forms signed are very different.

Deputy Seán Fleming:   Can the delegation task the clinical director with making sure the forms are signed every week? I will leave it at that.

Deputy Thomas P. Broughan:   I have some brief points following Deputy Fleming's analysis. On the delegation's review of economic costs, which has been the real issue and which the Comptroller and Auditor General has followed for us for the past number of decades, what is the current position regarding recovering the economic cost of providing public facilities for private use? What kind of benchmarking did the delegation use in regard to that? We got some indicative figures, but how far away are we from recovering the full economic cost of the public facilities?

Mr. Michael Scanlan: A figure in the Comptroller and Auditor General's report refers to current rates and is the HSE's 2009 average daily cost figure. It is on page 376. The charges increased virtually every year. I have figures going back to 2002, when the top level charge was €302. It is now €900. If one examines the White Paper from 1999 which I referenced - I do not have figures from that time - the Government policy enunciated then was to move towards economic charging and to be conscious of the impact on the private health insurance market. I do not have the figures in terms of percentages, but if the committee examines them it will see a regular increase each year.

In terms of the current position, in my opening statement I briefly mentioned the interim report, which I expect the Minister to receive in time for the budget. There is an issue with using the existing costings system and charging matrix and determining what space there might be to increase charges further. The reason there will be a second stage to that report is that there are a

number of more fundamental issues. When one discusses economic recovery or charging, the charging matrix comprises a series of some nine charges and various categories of hospital including private and semi-private. As it is an average cost it does not reflect, for instance, the nature of the procedure one received.

It may, of its nature, have an in-built inefficiency. Although a public hospital may be recovering its full costs, if it is inefficient it may actually be charging too much, which is not in anybody's interests. The HSE has been doing work on driving down the average length of stay in its own hospitals. I do not have evidence to back this up, but one would expect a private hospital which has a commercial interest to have an interest in trying to operate efficiently and get people through quickly. Perhaps we need to look in a more fundamental way at our charging regime.

Deputy Thomas P. Broughan: Can Mr. Scanlan give us any details? In our previous report a key recommendation was that we would implement a full charge for treatment and maintenance for a private bed in a public hospital. In its reply to us the delegation undertook to conduct an in-depth analysis, give us the parameters and narrow the gap. The gap still seems to be large. At the time of the report of the Comptroller and Auditor General, the figure was €758 for the private maintenance category A and it still seems to be significantly below what it estimates to be the economic cost, that is, €1,018. Semi-private beds seem to be in a similar situation. When can the delegation come to us with a report and indicate quite clearly what cost-benefit analysis it has done and what kind of parameters it has used, be it the private sector or hospital systems in other jurisdictions? Such a report would give us a real guideline as to how to maximise the impact of our public spending.

Mr. Michael Scanlan: To be fair, the charge of €758 was increased this year. The Comptroller and Auditor General's report refers to it. It went up by 20% since the committee asked us about it and it is now €910. To answer the Deputy's question, we expect to have the final report available in January, if not by the end of the year. We will have an interim report which I expect the Minister to receive before the budget.



Deputy Thomas P. Broughan: Will we be able to examine the report? Will the Oireachtas generally be able to see it?

Mr. Michael Scanlan: The Minister will decide what to do with it before the budget. I need to be careful what I say.


Deputy Thomas P. Broughan: I wish to ask Professor Drumm about a policy matter. The Minister told us many times in the Oireachtas the impact co-located hospitals should have on freeing up beds in our public hospitals for public patients. What is the current position of that policy? Planning permission has been secured for three hospitals and four sites are moving ahead. I understand it is not a direct responsibility of the delegation, but from its point of view does it see any easing of the pressure on the public and voluntary sector from that development. My party is completely opposed to this policy. Does the delegation see it impacting in a positive way in providing extra facilities in the public sector?

Professor Brendan Drumm: If patients were moved out of our hospitals to another hospital, that would open up capacity. It has always been my belief that capacity is not the issue rather it is performance that is the issue. It is what one does with that freed-up capacity that is important. It would not be useful to simply open up that capacity to allow us to again generate average lengths of stay that are way longer than they should be. It would be a benefit to us if we were to close the capacity that was freed-up and use that resource to develop our community services. It would be logical to do that.



Despite all our battles three or four years ago, with significantly fewer beds, having regard to long-stay and closed beds numbering approximately 1,500, we put through far more patients, having reduced our average length of stays and made our systems far more efficient. We have to retain that focus and put the money that is freed up into community services. If we moved that current hospital-based work into some other system and we move that resource in the right way in our system, we would benefit from that.

Chairman:   Is Mr. Heffernan from the Department of Finance aware if any estimate or study been done on the cost to the taxpayer of the subsidisation of private health care, which would include indemnity insurance, tax relief and so on?

Mr. Tom Heffernan: No, not that I am aware of.

Chairman:   Is Mr. Scanlan aware of any such study?

Mr. Michael Scanlan: I am not aware of one. The Chairman pointed to different elements. There is a figure for tax relief but one would have to do some work that would capture it all. I am not aware of such a study, unless there was some such study behind this work but I do not know if there was.

Deputy Róisín Shortall:   It is difficult to know how policy is devised if there are no figures for the cost of the different elements of the current system.

Mr. Michael Scanlan: There may be, but I am not aware of such a study. I have a figure for-----

Mr. Brendan Drumm: The tax relief element-----

Mr. Michael Scanlan: -----the tax relief element. If I do not have that figure here, I can forward it to the committee.

Mr. Brendan Drumm: -----is approximately €350 million.

Chairman:   What is the cost to the State of the indemnity insurance scheme?

Mr. Michael Scanlan: In terms of the clinical indemnity scheme, the payment to the State Claims Agency this year is €60 million. That covers public and private work on public hospital sites.

Chairman: One of the representatives from the Department of Finance might indicate the cost of tax relief on medical insurance?

Mr. Dermot Smyth: It is approximately €350 million. I can get my colleagues to provide that information.

Chairman: Like Deputy Shortall, I am surprised that no study has been done on this. We talk about a universal health scheme but the figures in that respect have not been done.

Deputy Seán Fleming: A large report on the cost of various tax reliefs was completed a year or two ago. It was the Indecon report. It was not related to this committee but it covered the cost of all tax reliefs. I am sure there is a section in it on the cost of tax relief for health insurance and other such measures. That report was done a year or two ago.

Chairman: Was it?

Deputy Seán Fleming: Yes.

Deputy Róisín Shortall: A recommendation in the report this committee produced on the health service was that a proper monitoring system should be put in place in terms of consultants who do not transfer to the new contract. I understand it was said that approximately 250 consultants have not transferred to the new contract. What are the new monitoring arrangements for them?

Mr. John Hennessy: The monitoring arrangements that exist for old contract holders are precisely the same as those for the new 2008 contract holders. The difference in respect of the follow-up arrangements is that very specific procedures are laid out in the 2008 contract in terms of follow up. The previous contract made less explicit provision but made allowance for activity to be controlled and contained to within the bed designation limits. The effect, ultimately, will be the same in respect of both.

Deputy Róisín Shortall: Some provision may have been made in the old contract for the split, but there was no supervision of that.

Mr. John Hennessy: It was not as explicitly stated as it is in 2008 contract.

Deputy Róisín Shortall: I accept that, but in terms of the new monitoring arrangements, what is the HSE's findings or is it too early to say? Can Mr. Hennessy give us any indication of what the HSE is finding in regard to those consultants who stayed on the old contract.

Professor Brendan Drumm: We could break it down separately.

Mr. John Hennessy: One could break it down separately but the activity in a particular hospital has a significant bearing on this. The example I might cite again is the mid-west area where there is not an alternative facility. Therefore, the private activity level tends to be higher than what one would find in a private inpatient facility. The impact of that has been twofold, first, the uptake on

the new contract has been lower and, second, the follow up has to cover both the new contract holders and the old contract holders.

Chairman: I ask Mr. Buckley to give his comments on what he has been listening to.

Mr. John Buckley: In terms of emphasising our role and the public accountability dimension, we would see it as important that, first, the affairs are ordered in such a way that the State gets full value for the money voted for the salaries of consultants by ensuring that they treat the quota of public patients they are paid to treat and, second, that the potential income from private patients treated is optimised. Clearly, a number of monitoring arrangements are being put in train and we will keep those under review. In particular, it will be interesting to see how the arrangements put in place in regard to the public-private mix work out and whether long term they may be able to substitute for some of the other - this is a policy matter - methods of attacking the problem, either from the maintenance or the treatment point of view.

From the maintenance point of view, the problem has been attacked in terms of limiting bed designation and so on. From the treatment point of view, the monitoring is based on a more informal persuasive system. It will be very interesting to see how that works out.

In regard to the optimisation of patient income, perhaps we need to do a bit more work there, both HSE management and us as auditors in the area of the utilisation of private beds. Perhaps the monitoring of the trend there over time can give a greater insight into how that is working out. Beyond that, it is a work in progress and we are all engaged in this. We will all have to keep it under review both from the point of view of the committee, management and the Comptroller and Auditor General's office.

Chairman: I thank Mr. Buckley. I forgot to ask if there are figures available for day case beds?

Professor Brendan Drumm: Does the Chairman mean the breakdown of private and public beds?

Chairman: Yes.

Professor Brendan Drumm: That will be in the data we will forward the committee.

Chairman: I thank everybody who contributed to today's session, the representatives from the Department of Health and Children, the HSE, the Department of Finance and our own members.

Is it agreed that the committee will dispose of chapter 37 - Management of Private Patient Income, and chapter 39 - Implementation of the Medical Consultants' Contract? Agreed.

The witnesses withdrew.

Chairman: Next week we will examine the Annual Report of the Comptroller and Auditor General and Appropriation Accounts: Vote 36 - Defence; Vote 37 - Army Pensions and chapter 28 - Mission to Chad.

The committed adjourned at 1.50 p.m. until 10 a.m. on Thursday, 12 November 2009.