R1-RWD

Secretary General

Non-compliance with Consultant Contract - public private practice

Background:

Proposed Action:
I attach a letter to the Director General of the HSE for your signature concerning consultants complying with the terms of their Contracts, in particular provisions relating to private practice.

The Department is also considering policy issues relating to private practice and HSE claims regarding conflicting policy imperatives arising from private income collection targets and the effect of the Health (Amendment) Act 2013.

Teresa Cody
National HR
17th July 2017

R2 - RWD

{In Archive} Consultant Contract - letters to HSE

Teresa Cody to: Paddy Barrett 17/07/2017 14:21

Cc: Sorcha Murray, Lindsey Maidment

Archive: This message is being viewed in an archive.

Paddy,

I've referred on the file to Sec Gen's office.

I've signed the other letter - please have it collected and issued to HSE.

Also. please see if you can arrange meeting with relevant people in HSE, DPER and Finance for next week.

My preferred dates are Tuesday 25th or Wednesday 26th - afternoons only.

Thanks,
Teresa

Teresa Cody, Assistant Secretary, National HR Division, Department of Health, Dublin DO2 VW90
: teresa_cody@health.gov.ie

Designated Public Official under the Regulation of Lobbying Act, 2015

http://emadublin.ie/

R3-R

An Roinn Sláinte
DEPARTMENT OF HEALTH

Oifig an Ard Rúnaí
Office of the
Secretary General

17th July, 2017

Mr Tony O'Brien
Director General
Health Service Executive
Dr Steevens' Hospital
Dublin 8

Re: Consultants complying with the terms of their Contracts, in particular provisions relating to private practice

Dear Tony,

The above issue has been the subject of detailed consideration and examination by the HSE in the context of preparation of the defence in the cases being taken by Consultants seeking payment of the increases specified in Consultant Contract 2008.

Consultant compliance with the Contract has arisen as an issue previously. On 1st October 2012 the Secretary General wrote to you concerning your intention to take the necessary steps to ensure that the management of individual hospitals (HSE or voluntary) and of hospital groups pursue full compliance with the terms of consultant contracts, including the provisions on private practice. That letter followed a meeting between the Department, the HSE and representatives of private hospitals at which they had enquired about Type B contract holders being permitted to have private practice off-site. The VHI had also raised questions around the issue at that time.

In response to the Secretary General's letter you issued clear instructions to relevant health sector management on 10th October 2012. You reaffirmed the need for individual hospitals and Hospital Groups to ensure full compliance with the terms of consultant contracts and the position set out in the guidance issued to the system by the National Director of Human Resources in May 2012 on Type B private practice.

I understand that returns made to the Office of the National Director HR, HSE in the context of the current process raise concerns that consultants may be exceeding their permitted level of private practice within the public hospital where they are employed, exceeding their off-site private practice rights or engaging in off-site private practice though holding a contract that does not permit any off-site private practice.

I would be grateful, therefore, if the HSE could take the necessary steps to ensure that all

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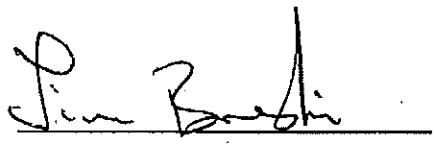
Hawkins House Dublin 2 Facs/Fax (01) 671 9884 Suíomh Gréasáin/Web www.doh.ie

consultants are reminded of their contractual obligations in relation to private practice and that processes are in place to ensure these obligations are fulfilled. I also request that appropriate corrective action is taken to ensure that anyone considered to be non-compliant adjusts their practice to ensure they fully meet the requirements of their contracts in this regard. I would also be grateful if you could arrange for submission of a report on corrective actions taken to this Department by 31st August 2017.

Yours sincerely



Jim Breslin
Secretary General

RL-RHD

{In Archive} Follow up to Ministers/MB meeting - Consultant Contract

Teresa Cody to: Paula Smeaton, KathyAnn Barrett 21/07/2017 10:46

Cc: Management Board - DoH, Sorcha Murray, Paddy Barrett, Lindsey Maidment, Derek McCormack

Archive: This message is being viewed in an archive.

Paula - for your records, you can bring this to the Minister's attention in due course. It is not urgent.

Kathy Ann - attached for information is the letter which the Secretary General mentioned yesterday.

This asks the HSE Director General to ensure that consultants are reminded of their contractual obligations in relation to private practice, that processes are in place to ensure those obligations are fulfilled; and that appropriate corrective action is taken where necessary. A report on corrective actions has been sought by 31st August.

Regards,
Teresa

Teresa Cody. Assistant Secretary. National HR Division. Department of Health, Dublin DO2 VW90

Designated Public Official under the Regulation of Lobbying Act, 2015

http://emadublin.ie/

Consultants compliance with terms of contracts.pdf

R5. RHD

{In Archive} Re: Minister seeking Consultants Contract briefing pl

Teresa Cody to: Paula Smeaton 21/11/2017 16:38

Cc: Lindsey Maidment, Sorcha Murray, Paddy Barrett, Joanne Lonergan, KathyAnn Barrett, secgen, James Breslin

Archive: This message is being viewed in an archive.

Paula,

Please find attached:

Briefing note for the Minister -

Note for the Minister re Consultant Contract Compliance. 21 Nov 2017- final.docx

Tab A - Sec Gen's letter of 17th July to the HSE Consultants compliance with terms of contracts.pdf

Tab B - HSE response dated 25th September :

- jim Breslin Sec Gen from Tony O'Brien re Consultants complying with terms of their contracts etc 25.09.17 DG Ref 457409.pdf

Tab C - DoH DRAFT comments on HSE paper attached to letter of 25th September

Comments on HSE policy paper on private practice.docx

I am available to discuss if required.

Teresa

Teresa Cody, Assistant Secretary, National HR Division, Department of Health. Dublin DO2 VW90

Paula Smeaton	Teresa, Minister is looking for the briefing on the...	21/11/2017 16:12:38

From: Paula Smeaton/SLAINTE
To: Teresa Cody/SLAINTE@SLAINTE, Sorcha Murray/SLAINTE@SLAINTE, Lindsey Maidment/SLAINTE@SLAINTE
Date: 21/11/2017 16:12
Subject: Minister seeking Consultants Contract briefing pl

Teresa,

Minister is looking for the briefing on the Consultants Contract please - and can you also include a copy of Sec Gen's letter to the HSE - and also a copy of their response.

Thanks

Paula Smeaton
Private Secretary to Minister Simon Harris T.D.
Department of Health
Hawkins House
Dublin 2

R6. RWD

Minister

Consultant Contract Compliance, in particular provisions relating to private practice

The Secretary General wrote to the Director General of the HSE on 17th July 2017 (Tab A) asking that the HSE take the necessary steps to ensure that all consultants are reminded of their contractual obligations in relation to private practice and that processes are in place to ensure these obligations are fulfilled. The Secretary General also requested that appropriate corrective action is taken to ensure that anyone considered to be non-compliant adjusts their practice to ensure they fully meet the requirements of their contracts.

The HSE responded on 25th September 2017 (Tab B) stating that:

(i) consultant contract compliance remains a matter of high priority for the HSE within its performance management framework;
(ii) responsibility for monitoring compliance has been devolved to the Hospital Groups but it remains an agenda item at monthly performance meetings held by the HSE Acute Hospitals Division with the Hospital Groups; and
(iii) that the National Director, Acute Hospitals Division has reminded the Groups to ensure that consultants are aware of their contractual obligations and that processes in place locally are observed.

The Department is finalising a further letter for issue to the HSE reiterating that it is essential that robust arrangements are put in place to actively monitor compliance with the provision of the contract by all consultants and to ensure corrective action is taken where any breaches are identified through the monitoring process. Options that could be explored to ensure a robust and credible approach include:- the auditing of individual hospitals returns and pursuit of corrective action, reconsideration of the decision to devolve the responsibility for monitoring and the putting in place of suitable organisational arrangements to deliver a robust compliance framework on an on-going basis.

The draft letter also states that irrespective of whether it is determined that monitoring and enforcement is best pursued at hospital group or national level, it is essential that a governance framework and related reporting and monitoring arrangements are put in place in respect of each consultant to ensure that they deliver their work commitment to the public system, that their private practice activity is in accordance with the levels permitted by their contracts and, where this is not the case, that the framework provides for the taking of corrective action.

On 25th September, the HSE also provided a draft paper setting out their view of challenges associated with oversight of private practice (see Tab B). The Department has given

consideration to the broader issues raised in this paper. Our response is being finalised following consultation with colleagues across the Department (Finance, Acute Hospitals and Primary Care Divisions) and a draft is attached for information (Tab C). It is not considered that the issues raised should affect the implementation of measures required to ensure robust governance and monitoring of compliance with the contractual provisions applicable to consultants engaging in private practice with remedial action pursued where breaches are identified.

Teresa Cody
Assistant Secretary
National HR Division

21 November 2017

RT City of Dublin

An Roinn Sláinte
DEPARTMENT OF HEALTH

Oifig an Ard Rúnaí
Office of the
Secretary General

17th July, 2017

Mr Tony O'Brien
Director General
Health Service Executive
Dr Steevens' Hospital
Dublin 8

Re: Consultants complying with the terms of their Contracts, in particular provisions relating to private practice

Dear Tony,

The above issue has been the subject of detailed consideration and examination by the HSE in the context of preparation of the defence in the cases being taken by Consultants seeking payment of the increases specified in Consultant Contract 2008.

Consultant compliance with the Contract has arisen as an issue previously. On 1st October 2012 the Secretary General wrote to you concerning your intention to take the necessary steps to ensure that the management of individual hospitals (HSE or voluntary) and of hospital groups pursue full compliance with the terms of consultant contracts, including the provisions on private practice. That letter followed a meeting between the Department, the HSE and representatives of private hospitals at which they had enquired about Type B contract holders being permitted to have private practice off-site. The VHI had also raised questions around the issue at that time.

In response to the Secretary General's letter you issued clear instructions to relevant health sector management on 10th October 2012. You reaffirmed the need for individual hospitals and Hospital Groups to ensure full compliance with the terms of consultant contracts and the position set out in the guidance issued to the system by the National Director of Human Resources in May 2012 on Type B private practice.

I understand that returns made to the Office of the National Director HR, HSE in the context of the current process raise concerns that consultants may be exceeding their permitted level of private practice within the public hospital where they are employed, exceeding their off-site private practice rights or engaging in off-site private practice though holding a contract that does not permit any off-site private practice.

I would be grateful, therefore, if the HSE could take the necessary steps to ensure that all

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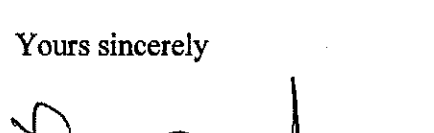
Hawkins House Dublin 2 **Facs/Fax** (01) 671 9884 **Suíomh Gréasáin/Web** www.doh.ie

consultants are reminded of their contractual obligations in relation to private practice and that processes are in place to ensure these obligations are fulfilled. I also request that appropriate corrective action is taken to ensure that anyone considered to be non-compliant adjusts their practice to ensure they fully meet the requirements of their contracts in this regard. I would also be grateful if you could arrange for submission of a report on corrective actions taken to this Department by 31st August 2017.

Yours sincerely



Jim Breslin
Secretary General

R8-R

Building a high quality health service for a healthier Ireland.
CARE | COMPASSION | TRUST | LEARNING

Director General of the Health Service
1st Floor, Dr. Steevens' Hospital, Dublin 8. Eircode D08 W2A8
Tel: (01) 635 2000 Fax: (01) 635 2211 Email: dgpa@hse.ie
@dghealthservice

25 September 2017

Our Ref: TO'B/SB
DG Ref: 457409

Mr Jim Breslin
Secretary General
Department of Health
Hawkins House
Dublin 2

Re: Consultants complying with the terms of their contracts, in particular provisions regarding private practice

Dear Jim,

I refer to your letter of the 17th July, 2017 regarding the above.

At the outset, I must re-iterate that consultant contract compliance remains a matter of high priority for the HSE within its performance management framework. You will be aware that the HSE has intervened in specific instances where we have not received satisfactory assurance regarding contract compliance. Responsibility for monitoring of consultant contract compliance has been devolved to the Hospital Groups; however, it remains an agenda item at the monthly performance meetings held by the HSE Acute Hospitals Division with the Hospital Groups. The National Director, Acute Hospitals Division, has reminded the Hospital Groups of the requirement to ensure that consultants are aware of their contractual obligations and that processes are in place locally to ensure that they are observed.

You will be aware that the HSE has had extensive discussions with officials from your Department and the Department of Public Expenditure and Reform on the current arrangements for oversight of private practice and consultant contract compliance. Following this engagement it was agreed that the HSE would prepare a paper that sets out the background to the consultant contract, the current oversight arrangements and the key challenges in terms of hospitals exercising their oversight function. The paper also sets out specific actions aimed at mitigating the challenges identified with a view to supporting improved compliance and oversight. We have sent this to HR Policy Division for their consideration. We have suggested that the HSE would meet with your officials to review the paper and agree appropriate actions.

I have attached a copy of this paper for your attention.

Yours sincerely,

Tony O'Brien
Director General

Stiúrthóir Ginearálta na Seirbhíse Sláinte
Urlár 1, Ospidéal an Dr. Steevens, Baile Átha Cliath 8
Eircode D08 W2A8

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

R.9 R

Vision

A healthier Ireland with a high quality health service valued by all

Mission

- People in Ireland are supported by health and social care services to achieve their full potential
- People in Ireland can access safe, compassionate and quality care when they need it
- People in Ireland can be confident that we will deliver the best health outcomes and value through optimising our resources

Values

We will try to live our values every day and will continue to develop them over the course of this plan

Care | Compassion | Trust | Learning

Resolution of issues relating to treatment of private patients in public health services and Consultant private practice

Draft of 4th August 2017

Table of Contents

Context

This paper has been prepared following engagement between the HSE, DOH and DPER on the issue oversight of consultant private practice. Within the context of discussions regarding the consultant contract claim issue, concerns have been raised by the regarding the level and appropriateness of current oversight arrangements relation to consultant contract compliance. At the request of DPER, the HSE agreed to prepare a paper that sets out the background to the consultant contract provisions, the types of consultant contracts and associated private income limits and how they are governed. As agreed, it also outlines some of challenges associated with the oversight of private practice having regard to changes in the contract and also in relation to income targets and income collection.

Background - Consultant Contract

Consultant Contract Provisions

The details of the contract types in the 2008, 1997 and 1991 consultant contracts are set out below. You will note that the pre-2008 contracts offer access to on-site private practice with the context of hospital designated private bed capacity whereas the 2008 contract delineates private work entitlements according to contract type. One of the critical considerations in agreeing the Consultant Contract 2008 related to the stated government policy on public/private co-location. Amongst other things, co-location identified the opportunity to offer greater access to surgery and hi-tech procedures. With co-location not proceeding there are challenges in terms of maintaining surgical skills and access to theatre which is further compounded by theatre closures.

2008 Contract

i) **Type A Consultants** cannot engage in 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, and medical/dental education and training bodies is not 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 is not regarded as private practice.

ii) **Type B Consultants** who:

a. In the post they now hold were previously employed under Consultant Contract 1997, the Academic Consultant Contract 1998, Consultant Contract 1991 or as Regional Consultant Orthodontists retain an entitlement to off-site outpatient private practice identical to that of a Category I Consultant under Consultant Contract 1997. This means that they may engage in outpatient private practice in private rooms so long as it does not include day case procedures requiring anaesthesia and subject to the Consultant fully discharging his/her aggregate 37-hour weekly standard commitment as required by the Employer. They may not – other than providing occasional consultations at the request of another Consultant – work in private hospitals or clinics of any type. They may also engage in in-patient, day-patient, out-patient or diagnostic private practice as appropriate in hospitals or facilities operated by the Employer, as part of such activities that arise as part of the employment contract (e.g. home visits) and in colocated private hospitals on public hospital campuses. Such private practice may not exceed 30% (or a lower figure as specified in their Contract) of the Consultant's clinical workload in any of his or her clinical activities, including in-patient, day-patient and outpatient.

b. OR Commenced employment in a permanent, locum or temporary post under Consultant Contract 2008 on a Type B basis They may engage in in-patient, day-

patient, out-patient or diagnostic private practice as appropriate in hospitals or facilities operated by the Employer, as part of such activities that arise as part of the employment contract (e.g. home visits) and in colocated private hospitals on public hospital campuses. Such private practice may not exceed 20% of the Consultant's clinical workload in any of his or her clinical activities, including in-patient, day-patient and out-patient. They have no entitlement to private practice off-site.

iii) **Type B*** Consultants are Consultants who were previously employed in a permanent temporary or locum capacity under Consultant Contract 1997, the Academic Consultant Contract 1998 on a Category II basis, Consultant Contract 1991 or as Regional Consultant Orthodontists when the contract was offered in July 2008. They retain an entitlement to off-site private practice identical to that of a Category II Consultant under Consultant Contract 1997. This means that they may engage in off-site private practice in private rooms, hospitals clinics or otherwise subject to subject to the Consultant satisfying the employing authority that he or she is fulfilling their contractual commitment to the public hospital(s) and such private practice being confined to periods outside the aggregate 37 hour weekly commitment and other scheduled commitments to the public service. They may also engage in in-patient, day-patient, out-patient or diagnostic private practice as appropriate in hospitals or facilities operated by the Employer, as part of such activities that arise as part of the employment contract (e.g. home visits) and in co-located private hospitals on public hospital campuses. Such private practice may not exceed 30% (or a lower figure as specified in their Contract) of the Consultant's clinical workload in any of his or her clinical activities, including in-patient, day-patient and out-patient. Type B* is not available to Consultants who were not in post at the time of the offer of Consultant Contract 2008 in July 2008.

iv) **Type C** Consultants may engage in off-site private practice in private rooms, hospitals, clinics or otherwise subject to the Consultant fully discharging his/her aggregate 37-hour weekly standard commitment as required by the Employer. They may also engage in in-patient, day-patient, out-patient or diagnostic private practice as appropriate in hospitals or facilities operated by the Employer, as part of such activities that arise as part of the employment contract (e.g. home visits) and in co-located private hospitals on public hospital campuses. Such private practice may not exceed 20% of the Consultant's clinical workload in any of his or her clinical activities, including in-patient, day-patient and out-patient.

Consultant Contract 1997 / Academic Consultant Contract 1998

i) **Category I Consultants** must devote substantially the whole of their professional time to the public hospital. They may engage in off-site outpatient private practice in private rooms so long as it does not include day case procedures requiring anaesthesia and subject to the Consultant satisfying the employing authority that he or she is fulfilling their contractual commitment to the public hospital(s). They may not – other than providing occasional consultations at the request of another Consultant – work in private hospitals or clinics of any type. They may also engage in on-site private practice subject to the requirement that a Consultant's overall proportion of private patients should reflect the ratio of designated private beds.

ii) **Category II Consultants** may engage in off-site private practice in private rooms, hospitals, clinics or otherwise subject to the Consultant satisfying the employing authority that he or she is fulfilling their contractual commitment to the public hospital(s). They may also engage in on-site private practice subject to the requirement

that a Consultant's overall proportion of private patients should reflect the ratio of designated private beds.

Consultant Contract 1991

i) **Geographical Wholetime Consultants** must devote substantially the whole of their professional time to the public hospital. They may engage in off-site outpatient private practice in private rooms so long as it does not include day case procedures requiring anaesthesia and subject to the Consultant satisfying the employing authority that he or she is fulfilling their contractual commitment to the public hospital(s). They may not – other than providing occasional consultations at the request of another Consultant – work in private hospitals or clinics of any type. They may also engage in on-site private practice. The Consultant Contract 1991 does not specify any restrictions on same.

ii) **Existing Wholetime Consultants** may engage in off-site private practice in private rooms, hospitals, clinics or otherwise subject to the Consultant satisfying the employing authority that he or she is fulfilling their contractual commitment to the public hospital(s). They may also engage in on-site private practice. The Consultant Contract 1991 does not specify any restrictions on same.

Oversight arrangements

Prior to establishment of Groups, the central oversight of individual consultants based on HIPE and under the framework of HSE Consultant Contract Implementation Guidance document version IV. A decision was made in 2013 at Leadership Team to devolve this responsibility to the Hospital Groups and that it be addressed through their performance arrangements with Hospitals. Part of the rationale for this approach related to the fact that the contract provides for exceptions – small volume / national specialist services and also provides guidance in relation to joint appointments and measurement arrangements. Also, in light of the complexities in relation to income generation and requirement for regular review of work plans, it was felt that the monitoring and management must be exercised at the hospital level with oversight from Groups.

In terms of intervention, the DOH and DPER will be very aware of those circumstances where HSE at national level intervened directly with hospitals and /or Groups where it had concerns about compliance with the provisions in relation to public /private mix.

The HSE has established a process that limits access to Category C contracts where a formal application is made to a high level national group under the National Director, Acute Hospitals with representation from the Department of Health. The Type C committee requires each consultant to prepare a report after one year that shows the impact of their contract on stated reasons – skill/access etc.

Current performance - public/private mix

The HSE collects and reports information from HIPE monthly, in arrears, in relation to the percentage of public and private work being undertaken at each Hospital on an elective in-patient basis and on a day-case basis. Latest data from February 2017 shows public private mix at a system level stands at 81% public for elective in-patient work and over 85% for day-case work and performance has been consistent at this level.

For those sites where there is higher than 30% private practice, there are relevant factors including original bed designation (St John's Hospital absence of private facilities in the area or service (e.g. paediatrics, maternity services) and supra regional or national specialist services e.g. Cancer

Contract compliance is an agenda item on the monthly Hospital Group performance meetings. The responsibility for management of individual consultant compliance with the contract, including adherence to public/private ratios, was formally delegated to the Hospital Groups in 2014. This responsibility was delegated for a number of reasons, including:

- Ensuring accountability and responsibility was devolved to Hospital Groups
- Recognition that joint appointments/cross hospital work arrangements and the effect on private work could only be assessed locally
- Guidance regarding exemptions, as per the contract, could only be applied locally

From our review of public private mix compliance with hospitals and groups and our broader review of financial performance through the accountability framework a number of key challenges have been identified that pose challenges in terms of groups exercising their oversight function. These are set out below in an effort to demonstrate the need for improved alignment of the 4 performance domains but also to put forward some suggestions as to how to mitigate these challenges

The key challenges identified are as follows:

- The decision to de-designate private beds was aimed at optimising private income and supporting the delivery of accelerated income targets. However for those on the pre 2008 contracts where the private income limits were based on designation this posed unique challenges for this cohort as it left no effective basis for measuring compliance. There are 360 consultants in this cohort (i.e. approx 10%)
- The contract makes no provision monitoring of offsite private practice. The HSE has audited hospitals in relation to this issue; however it does not lend itself to a routine monitoring and random checks through websites have limited benefit. There is a need to determine the most appropriate mechanism for establishing whether there is inappropriate off site practice
- There are no mechanisms to allow HSE to determine whether consultants have received remuneration for private work undertaken. The HIPE data measures the patient's status; this does not mean that the consultant was paid for such work. For example, at the end of September 2017 there are up to €1.7m in claims at risk relating to requirements for submission of appropriate paperwork with consultant sign off.
- Need to consider how best to align the requirements in relation to income generation and collection with private practice limits.
    - The setting of income generation targets must have regard for the overall public private compliance limits
    - Insurer requirement for sign off by consultants on private health insurance claims creates practical challenges in terms of limiting those same consultants private income
    - For Type A consultants , there is a need to maintain the potential for income generation without compromising patient choice
- Need to review and re-align DOH guidance with eligibility regulations regarding determination of patient status (public/private)
- Monitoring all aspects of the contract – The 2008 contract provides for structured on-site attendance where people are required to work in excess of contracted hours. There are Consultants that work in excess of 39 hours and strict enforcement of the contract will bring this issue into sharp focus. The contract also provides for (at Section 21, Consultant Contract

Type B, c)) that "Where a Consultant holding Contract Type B cannot be provided with facilities on the hospital campus for outpatient private practice the employer shall make provision for such facilities off-campus, on an interim basis, pending provision of on-campus facilities." The HSE has argued that the nature of such provision is unclear, however, HSE acknowledges that it will involve the employer supporting, in some way, the provision of facilities off-campus if on-campus facilities are not available.

Key issues

1. Bed designation - private practice for Consultants on 1997 and 1998 Contracts

a) Legislative changes affecting bed designation

Arising from regulations made by the Minister for Health under the Health (Amendment) Act 2013 changes were made to the charging of patients holding private health insurance in public hospitals. Previously, patients were required to opt for private status and to be accommodated in a designated 'private' bed prior to becoming eligible for an accommodation charge. The changes meant that persons holding private health insurance could be charged irrespective of whether they were accommodated in a private bed or not. Effectively, the distinction between designated 'private', 'public' and 'non-designated' beds and related treatment spaces (such as couches etc) was removed and all beds became chargeable in respect of levies for private accommodation.

While the changes described above are not relevant to the private practice of Consultants holding Consultant Contract 2008 – which regulates private practice by measuring volume of caseload adjusted by complexity of same – they directly affect the extent to which the 365 Consultants on either the 1997 Contract or the 1998 Academic Consultant Contract can engage in private practice.

b) Extract from Consultant Contracts 1997 and 1998

Section 2.9.3 of the Memorandum of Agreement attached to Consultant Contract 1997 – and the Academic Consultant Contract 1998 - states that:

> "With regard to on-site private practice, a consultant's overall proportion of private to public patients should reflect the ratio of public to private stay beds designated under the 1991 Health (Amendment) Act which requires that all public hospital beds be classified as public, private or non-designated."

Taking the above into account, all public hospital beds were designated as public, private or non-designated beginning in the early 1990s. The extent to which beds were designated varied significantly – from 45% designated private beds in St John's Hospital, Limerick to less than 10% in St Vincent's University Hospital or the Mater Misericordiae University Hospital.

The effect of the changes introduced under the Health (Amendment) Act 2013 is to allow all public hospital beds to function as designated private beds should they be filled by a patient with private health insurance. In that regard, there is no meaning to the terms 'public bed' or 'private bed'. 100% of public hospital beds now function as designated private beds. This removes any contractual limit on on-site private practice for the 365 Consultants holding the 1997 Consultant Contract or 1998 Academic Consultant Contract.

c) Proposed approach

Noting the above the mechanism for management of private practice under Consultant Contract 1997 is founded on a regulatory regime which has now been amended by legislation. On examination, there appear to three potential approaches:

- The Department of Health issues a circular clarifying the extent to which the regulatory regime (including bed designation) introduced following the Health (Amendment) Act 1991 remains in place. Such a circular would have to confirm that notwithstanding the facility for charging patients with private health insurance irrespective of bed designation introduced under the Health (Amendment) Act 2013 that designated public and private beds / treatment spaces remained in existence.
- An amendment is negotiated between the employers and the medical unions to Consultant Contract 1997. This appears highly unlikely.

Legislation is passed providing for the continued existence of designated beds. This appears to be both a difficult and perhaps unnecessary course if the same action could be achieved by way of circular.

2. Addressing off-site private practice where it is in breach of contract

a) Background

In the period since 2008 instances of non-compliance with the requirements of Consultant Contract 2008 regarding the location of private practice have been identified. These requirements differ depending on Contract Type. For example, Type A Consultants may not engage in private practice irrespective of location, Type B Consultants who transferred to Consultant Contract 2008 from Consultant Contract 1997 retain access to off-site out-patient private practice but not in private hospitals or clinics. New entrant Type B Consultants (since March 2008) cannot engage in off-site private practice of any kind. Where Type B Consultants were engaged in medical practice in private hospitals or clinics often, the option to seek change in Contract type to Type C or Type B* to support contractually compliant offsite private practice had not been initiated. This issue arose in Galway, Limerick and Dublin in particular.

In terms of performance of the Contract, the HSE has intervened with individual hospitals and has sought assurance regarding compliance (Mater, SVUH, Limerick) . It also audited compliance where it has failed to secure assurance. Difficulties include absence of any contractual provision or agreed mechanisms relating to monitoring of such breaches of contract. This has been further compounded by the inability to offer appropriate access to theatre and other facilities in line with the agreed work plans. The provisions within (at Section 21, Consultant Contract Type B, c)) that "Where a Consultant holding Contract Type B cannot be provided with facilities on the hospital campus for outpatient private practice the employer shall make provision for such facilities off-campus, on an interim basis, pending provision of on-campus facilities." are relevant here. It is fully accepted that the HSE needs to be able to demonstrate appropriate oversight in this area

b) Proposed approach

Noting the above, Consultants engaged in offsite private practice obtain a significant volume of their private income via health insurance providers (who reimburse the Consultant for services provided

to insured persons). One such health insurer is the VHI, an agency under the aegis of the Department of Health it is proposed that the Department of Health assign the power to the Health Insurance Authority to require health insurers to only reimburse those Consultants who are employees of the public health service where such Consultants have the contractual authority to engage in private practice in public hospitals, private hospitals, private clinics or in any other setting.

This would introduce a regulatory mechanism which would dis-incentivise Consultants from breach of their public employment contractual commitments.

3. Employers impose conflicting private practice requirements on Consultants

a) Conflicting policy imperatives

A range of policies regarding collection of private income to fund delivery of public hospital services appear to conflict with the need to assure compliance with the public / private practice requirements of Consultant Contract 2008.

Firstly, each year the HSE identifies a private income target for each acute hospital based on the previous year's expenditure. Private income provides funding to meet the difference between funding provided by the Department of Health and actual public hospital expenditure. Targets are set with regard to the capacity of the hospital to generate income and the need to maintain – based on Consultant Contract 2008 - a national ratio of public to private patients at 80/20.

In this regard, the HSE Service Plan 2016 as approved by the Minister for Health requires that acute hospitals private income receipts vary from planned targets by no more than 5% and that measures were taken to promote the improved generation and collection of private charges income within acute hospitals.

In 2016, the HSE has identified a private income funding requirement of approximately €633m; in addition there is a requirement for accelerated income of €44m.

b) Arrangements for collection of accommodation charges

Secondly, despite attempts to renegotiate the arrangement, private health insurance companies link payment of the accommodation charge to the hospital to the separate claim for a clinical treatment or procedure. This means that hospitals can only receive payment for use of a bed by a private patient where the treating Consultant has confirmed that they treated the patient privately.

In this context, the September 2012 'Consultants Implementing the Public Service Agreement' document set out the following:

> "vii) Timely and efficient management of private patients
>
> Consultant facilitation and implementation of measures to support collection of income arising from the treatment of private patients in public hospitals, including:
>
> a. A commitment from all Consultants to fully complete and sign private insurance forms within 14 days of receipt of all the relevant documentation. The purpose of this provision is to effect a significant reduction in outstanding income due to the public

health system. Persistent failure to comply will be addressed by the employer and it is noted that the employer has full authority to take the steps necessary to resolve the matter.

b. Co-operation with the Secondary Consultant scheme whereby a secondary Consultant involved in a case can sign the claim form if the primary consultant has not signed within a reasonable timeframe. The current timeframe in operation with the VHI is claims older than three months. Health service management wish to reduce this and the timeframes operated by other health insurers to one month and commit to supporting Consultants to achieve their responsibilities in this regard.

c. Co-operation with the implementation of electronic claim preparation and submission in the manner required by the insurer (the HSE has recently awarded a tender for the introduction of an electronic claims management system in eleven of its key hospitals).

d. Co-operate with the implementation of reasonable changes that may be introduced to generate and collect additional income."

c) Conflict with requirement to ensure equitable treatment of public patients in public hospitals

Noting the above, the Consultant Contract 2008 is now the main mechanism giving effect to national policy regarding equitable access for public patients to public inpatient services. Nevertheless, in order for hospitals to secure sufficient accommodation income from private patients to meet expenditure requirements, Consultants are both required and incentivised to treat and charge a particular volume of private patients without reference to contractual limits.

In the face of this potential conflict of interest and as noted previously, the Contract provides Consultants with a number of options. Firstly, they may choose to treat patients in excess of their ratio as public patients. Secondly, they can treat patients privately but not charge. Finally, they can treat patients privately, charge and remit the excess fees to the Research and Study Fund.

There is however no evidence that Consultant's make use of these options. Instead some Consultants – and some hospitals – argue that Consultants in settings where a significant proportion of patients attending or referred or private cannot be expected to do anything other than treat attending / referred private patients privately. The HSE has no basis to determine whether the Consultant actually received remuneration for private patients treated beyond contract limits.

d) Proposed approach

Taking the above into account it is proposed that the Department of Health work with the HSE, the Health Insurance Authority and health insurers to separate the payment of accommodation charges from the Consultant's private contractual relationship with the patient. One way to achieve this would be for the health insurer to receive some form of certification that the accommodation of the patient was medically necessary, perhaps by way of regular independent audit and provision for remittance of payments from the hospital to the insurer if some period of accommodation was found to be unnecessary.

This would have the effect of removing any connection between the hospital collection of private income for patient accommodation and the regulation of Consultant private practice.

4. Admission by Type A Consultants - patient status

a) Summary

Since 2009, arising from an instruction by the Department of Health, patients admitted by Type A Consultants lose the ability to opt for private status on admission or subsequently, in contrast to patients admitted by Consultants holding any other type or category of contract. This has resulted in a loss of private income for hospitals and meant that Type A Consultant posts have not been created in most admitting specialities across the public hospital system. A further issue is that the Department's instruction is conflict with the eligibility regulations set out in Department Circulars arising from the Health (Amendment) Act 1991 and rendered incoherent the regime in place for the treatment of public and private patients in the public hospital system.

b) Background

DoH Circular No 1 of 1991 set out the matters covered in regulations made by the Minister for Health under the Health (Amendment) Act 1991 regarding eligibility for care in public hospitals. The Circular states in regard to 'Determination of public or private status of an in-patient' that:

> "It will be an essential element of the new arrangements that the public or private status of a patient must be specified on admission and the patient identified as a private patient will be liable for the fees of all consultants involved in his or her care. The definition of 'private status' is that the patient is opting to avail of private consultant services rather than the public consultant services available under the Health Act. Membership of a health insurance scheme, does not, of itself, imply private status.
>
> Where a patient is being admitted arising from a private out-patient consultation, it will be presumed that he or she is a private patient unless the patient specifies to the contrary and this is confirmed by the consultant.
>
> If a patient admitted in emergency circumstances is unable to opt (or have a relative opt on his or her behalf) for either status but subsequently opts for private status, he or she will be regarded as a private patient from admission and therefore liable for the fees of all Consultants involved in his or her care from admission." (DoH Circular No 1 of 1991, 3)

DoH Circular No. 5 adds the following:

> "However, where a patient remains private to the consultant for the out-patient element of a programme of care which includes both out-patient and in-patient treatment (e.g. obstetrics) the patient is not entitled to opt for public status as an inpatient." (DoH Circular No 5 of 1991, 2, 3)

Taking the above into account and in the absence of any amendments to the regulations or related circulars, Volume III, Section 5 of Guidance to health service management on the implementation of Consultant Contract 2008 stated:

> "Consultants holding Contract Type A may treat private patients. While such Consultants may not charge fees for such services, the Contract Type held by the Consultant does not alter the patient's designation as a public or private patient."

In early 2009 a number of health insurance companies queried whether patients admitted by Type A Consultants could opt to be treated as private patients. The matter was considered by the Department of Health & Children who wrote to the HSE on 23rd March 2009 stating:

> "The position is that a patient may only be regarded as having "private" status where he/she opts to avail of private consultant services rather than public consultant services under the Health Acts. As Category A Consultants do not undertake any private work, there is no basis on which a patient under the care of such a consultant could be accorded "private" status."

c) Issues arising

The effect of the Department's communication referenced above is that patients admitted by a Type A Consultant are deemed to be public patients for the duration of their hospital stay irrespective of source of referral, any request they may make to be treated privately or subsequent transfer – after admission – to a Consultant entitled to engage in private practice. In that regard, such patients, if admitted in emergency circumstances and unable to opt for a particular status at the time, lose the ability to do so. In addition, patients undergoing a programme of care which which includes both out-patient and in-patient treatment (e.g. obstetrics) who are private during the out-patient element may subsequently have public status imposed on them if admitted by a Type A Consultant.

Patients admitted by Type B, Type B*, Type C, Category I, Category II or other Consultants entitled to engage in private practice may be determined to be either public or private patients or may choose to opt for private status at a later stage following admission.

In that context, for patients admitted or treated by Type A Consultants, private status is no longer determined by reference to the source of referral, patient choice or agreement by the Consultant (as per DoH Circulars) but by reference to the contract type held by the individual admitting or treating consultant. In contrast, were the patient to be referred on to a Type B, B*, C, Category I or Category II Consultant, determination of patient status reverts to source of referral.

The interpretation offered by the DoH letter of 23rd March 2009 directly contradicts the provisions of DoH Circulars No 1 and No 5 of 1991 regarding the determination of the public or private status of inpatients and outpatients and introduces a new means of making such a determination.

The effect of the interpretation has been to severely limit the number of Type A posts in specialities outside Psychiatry and Emergency Medicine. Hospitals are acutely aware that the presence of a Type A Consultant on an on-call rota has the effect of converting a mixed stream of public and private patients – some of whom may in normal circumstances be expected to generate private income for the hospital – into a stream of public only patients, without patient consent. In such circumstances hospitals have consistently failed to advance applications for Type A posts.

Two examples of how the public and private status of patients is managed are set out below:

<u>Scenario 1</u>
A Patient is admitted under a Type A Consultant and is subsequently transferred to a Type B / Type B* / Type C / Category I / Category II Consultant. The patient holds private health insurance which he or she wishes to use. The patient remains public for the duration of their stay in hospital as they were admitted by a Type A Consultant.

Scenario 2

A Patient is admitted under a Type B / Type B* / Type C / Category I / Category II Consultant, has private health insurance and is being billed by the Consultant. The patient is also being billed by the hospital for private accommodation as they have private health insurance. The patient is transferred to a Type A Consultant. The patient remains private to the hospital as they have private health insurance and remains eligible for private fees from other Type B, Type B*, Type C, Category I or Category II Consultants should they provide any treatment or diagnostic services. The Type A Consultant cannot charge the patient any fees.

d) Arbitration by Mark Connaughton SC

This matter became the subject of arbitration by Mark Connaughton SC has Chair of the Consultant Contract 2008 Implementation Group. Following receipt of submissions on the matter, he wrote to the parties on 26th April 2010 stating:

> "Concern has also been expressed by both Consultant Organisations that there has been an apparent change of approach to the determination of the question, when a person admitted can avail of private care following admission. Reference is made in this regard to the determination by the Department of Health and Children that patients admitted under a Type A Consultant must, throughout their stay, be designated as public patients. Reliance is also placed on what are generally referred to as the *eligibility regulations* comprised in Circular 5 of 1991. It is suggested by both Consultant Organisations that the approach adopted shows considerable inflexibility and does not accord with their understanding throughout the negotiations or indeed, the text of the Circular taken as a whole.
>
> I think there is merit in the argument of both sides on this issue. On the one hand, it is clear that the Regulations have not changed but the direction from the Department of Health and Children to which I refer does appear to have altered the practice.
> It would be wholly unsatisfactory if the essential purpose of the 1991 Regulations was to be frustrated. The element of patient choice must also be respected, as per those regulations. However, it strikes me that further discussions between all of the relevant parties, including the Department of Health and Children, could produce agreement consistent with the essential principles enshrined in the relevant Circular and the Consultant Contract."

e) Proposed approach

It is proposed that the DoH formally communicate to the HSE by way of circular that the approach described in DoH Circulars No 1 and No 5 of 1991 regarding determination of patient status remains in place subject only to amendment arising from regulations issued under the Health (Amendment) Act 2013. This would mean that a single, consistent regime was in place for determination of public or private status irrespective of the contract held by the admitting Consultant. Persons admitted by a Type A Consultant would be able – on referral to a Consultant of a different contract type or category or in relation to private accommodation to opt for private status and would be regarded therefore as private patients from their admission onwards. No fees would accrue to the Type A Consultant in any circumstances. A barrier to the creation of Type A Consultant posts in admitting specialties would be removed and it is anticipated the number of Type A Consultants would grow as a proportion of the Consultant workforce.

R10. -RWD.

{In Archive} Re: Fw: Paula, could you request a one pager for Minister setting out types of consultant contracts asap please? Thanks, Jo

Teresa Cody to: Paula Smeaton 21/11/2017 18:55

Cc: Lindsey Maidment, Sorcha Murray, paddy_barrett, Joanne Lonergan

Archive: This message is being viewed in an archive.

Paula

1 pager with additional explanatory material is attached.

Teresa

Teresa Cody. Assistant Secretary. National HR Division, Department of Health, Dublin DO2 VW90

Designated Public Official under the Regulation of Lobbying Act, 2015

From: Paula Smeaton/SLAINTE

To: Sorcha Murray/SLAINTE@SLAINTE, Lindsey Maidment/SLAINTE@SLAINTE, Teresa Cody/SLAINTE@SLAINTE

Date: 21/11/2017 18:11

Subject: Fw: Paula, could you request a one pager for Minister setting out types of consultant contracts asap please ? Thanks, Jo

Can someone pl provide asap - as per above.

Many thanks

Paula Smeaton
Private Secretary to Minister Simon Harris T.D.
Department of Health
Hawkins House
Dublin 2

----- Forwarded by Paula Smeaton/SLAINTE on 21/11/2017 18:10 -----

From: Joanne Lonergan/SLAINTE

To: Paula Smeaton/SLAINTE@slainte

Cc: KathyAnn Barrett/SLAINTE@slainte

Date: 21/11/2017 18:07

Subject: Paula, could you request a one pager for Minister setting out types of consultant contracts asap please ? Thanks, Jo

Sent from my iPhone

 - Consultant Contract Types.docx

R11- R

Consultant Contract Types

The Contract allows consultants engage in differing levels of private practice, depending on the contract type held.

Consultants holding a Type A contract are not permitted to engage in privately remunerated professional practice.

Consultants holding a Type B contract may undertake private practice on-site, up to a limit of 20% of activity on a casemix-adjusted basis, and limited off-site private practice in cases where the individual consultant previously held a Category I or Category II contract under Consultant Contract 1997.

Serving consultants whose public to private ratio in 2006 was greater than 20% are permitted to retain this higher ratio, subject to an overriding maximum ratio of 70:30%.

Consultants holding a B* (Star) Contract or a Type C Contract may engage in off-site private practice. Their in-patient and out-patient private practice activity in the public hospital is subject to the 20% maximum limit.

There are 3,189 consultants in the Irish healthcare system of which 17% hold Category A contracts, 58% hold Category B, and the remainder are category B* - 10%, category C - 5%, or 1997 Category 1 and 2 consultants - 10%.

Attached is copy of section 20 of the Contract which sets out the criteria in each case.

National HR Unit
21 November 2017

R11-R

20. Regulation of private practice

a) Subject to the provisions of this section, the Consultant may engage in privately remunerated professional medical/dental practice as determined by his or her Contract Type as described at Section 21 below.

b) The volume of private practice may not exceed 20% of the Consultant's workload in any of his or her clinical activities, including in-patient, day-patient and out-patient.

c) The volume of practice shall refer to patient throughput adjusted for complexity through the medium of the Casemix system.

d) The 80:20 ratio of public to private practice will be implemented through the Clinical Directorate structure. The Employer has full authority to take all necessary steps to ensure that for each element of a Consultant's practice, s(he) shall not exceed the agreed ratio.

e) The Consultant will be advised on a timely basis 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 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.

f) The Clinical Director may exercise some discretion in dealing with the implementation of the ratio either for an individual or a group of Consultants once the overall ratio in relation to the particular clinical activity is satisfied.

g) The implementation of the 80:20 ratio of public to private practice shall be the subject of audit including audit by the Department of Health and Children.

21. Contract Type

Consultant Contract Type A

a) A Consultant holding Contract Type A may engage in professional medical/dental practice exclusively for the public Employer(s) or as provided for at (c) below.

b) A Consultant holding Contract Type A shall not engage in privately remunerated professional medical/dental practice. (S)He can only be remunerated for professional medical practice by way of salary as an employee under this contract or as provided for in (c) below.

c) Professional medical/dental practice carried out for or on behalf of the Mental Health Commission, the Coroner, other Irish statutory bodies[1], 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.

[1] An indicative list of such bodies is available from the HSE Employers Agency, 63-64 Adelaide Road, Dublin 2, tel: 01 6626966, web: www.hseea.ie

The HSE may specify additional bodies[12] dealing with public patients or aspects of the public health system to which this provision will also apply. The use of public facilities for all such activities is subject to the prior agreement of the Employer.

Consultant Contract Type B

a) A Consultant holding Contract Type B may engage in privately remunerated professional medical/dental practice only in hospitals or facilities operated by the Employer, as part of such activities that arise as part of the employment contract (e.g. home visits), colocated private hospitals on public hospital campuses and as described at (b) below.

b) A Consultant holding Contract Type B who previously held a Category I or Category II Contract under the Consultants Contract 1997 may continue to hold the right to engage in privately remunerated professional medical/dental practice in locations outside the public hospital campus, subject to the Consultant fully discharging his/her aggregate 37-hour weekly standard commitment as required by the Employer and such private practice being commensurate with the entitlement to off-site private practice held by a Category I Consultant under the Consultants Contract 1997[2];

c) Where a Consultant holding Contract Type B cannot be provided with facilities on the hospital campus for outpatient private practice the Employer shall make provision for such facilities off-campus, on an interim basis, pending provision of on-campus facilities.

d) The volume of private practice as described at (a) and (c) may not exceed 20% of the Consultant's clinical workload in any of his or her clinical activities, including in-patient, day-patient and out-patient.

e) With respect to Emergency and Outpatient Departments specifically, the Consultant shall not charge private fees in respect of:

   i) patients attending Emergency Departments in public hospitals;
   or
   ii) patients attending Public Outpatient Services in public hospitals.

f) A common waiting list operated by the public hospital will apply to both public and private patients undergoing diagnostic investigations, tests and procedures (including radiology and laboratory procedures) on an out-patient basis in public hospitals (including referrals from General Practitioners). Status on the common waiting list will be determined by clinical need only. The list will be subject to clinical validation by the relevant Clinical Director.

   The Consultant may charge private fees in relation to private patients undergoing diagnostic investigations, tests and procedures on an outpatient basis subject to:

   i) the common waiting list provisions described above;

   ii) all billing being processed by the Consultant in a manner that is satisfactory to the hospital and in the event that insufficient information is available for verification

[2] Sections 2.9.4 to 2.9.7 inclusive of the Memorandum of Agreement attached to the Consultants Contract 1997 refer. These are attached at Appendix V.

purposes recourse may be had to the measures provided for at Section 20 (d) and (e);

iii) the volume of such private practice not exceeding 20%.

g) The Consultant may charge private fees in relation to diagnostic investigations, tests and procedures (including radiology and laboratory procedures) referred to the public hospital by private hospitals, private clinics or other sources outside of the public health system but only where all arrangements for such referrals are effected through the Employer.

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

The HSE may specify additional bodies dealing with public patients or aspects of the public health system to which this provision will also apply. The use of public facilities for all such activities is subject to the prior agreement of the Employer.

Consultant Contract Type B*

h) Contract Type B* is immediately available to:

i) A Consultant who held a Category II Contract under the Consultants Contract 1997; subject to the Consultant fully discharging his/her aggregate 37-hour weekly standard commitment as required by the Employer.

ii) A Consultant who held a Category I or II Contract as a Consultant in Emergency Medicine under the Consultants Contract 1997, subject to the Consultant fully discharging his/her aggregate 37-hour weekly standard commitment as required by the Employer.

b) A Consultant who held a Category I Contract under the Consultants Contract 1997 may apply to change Contract Type to Contract Type B* two years after taking up Contract Type A or B.

c) A Consultant holding Contract Type B* may engage in privately remunerated professional medical/dental practice in:

i) hospitals or facilities operated by the Employer;

ii) as part of such activities that arise as part of the employment contract (e.g. home visits), and/or in colocated private hospitals on public hospital campuses;

iii) in locations outside the public hospital campus, subject to such private practice being:

(1) commensurate with the entitlement to off-site private practice of a Category II Consultant under the Consultants Contract 1997; and
(2) confined to periods outside the aggregate 37 hour weekly commitment and other scheduled commitments to the public service.

d) The volume of private practice as described at (c) i) and ii) may not exceed 20% of the Consultant's clinical workload in any of his or her clinical activities, including in-patient, day-patient and out-patient.

e) With respect to Emergency and Outpatient Departments specifically, the Consultant shall not charge private fees in respect of:

i) patients attending Emergency Departments in public hospitals,

or

ii) patients attending Public Outpatient Services in public hospitals.

f) A common waiting list operated by the public hospital will apply to both public and private patients undergoing diagnostic investigations, tests and procedures (including radiology and laboratory procedures) on an out-patient basis in public hospitals (including referrals from General Practitioners). Status on the common waiting list will be determined by clinical need only. The list will be subject to clinical validation by the relevant Clinical Director.

The Consultant may charge private fees in relation to private patients undergoing diagnostic investigations, tests and procedures on an outpatient basis subject to:

i) the common waiting list provisions described above;

ii) all billing being processed by the Consultant in a manner that is satisfactory to the hospital and in the event that insufficient information is available for verification purposes recourse may be had to the measures provided for at Section 20 (d) and (e);

iii) the volume of such private practice not exceeding 20%.

g) The Consultant may charge private fees in relation to diagnostic investigations, tests and procedures (including radiology and laboratory procedures) referred to the public hospital by private hospitals, private clinics or other sources outside of the public health system but only where all arrangements for such referrals are effected through the Employer.

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

The HSE may specify additional bodies dealing with public patients or aspects of the public health system to which this provision will also apply. The use of public facilities for all such activities is subject to the prior agreement of the Employer.

Consultant Contract Type C

a) A Consultant holding Contract Type C may engage in privately remunerated professional medical/dental practice in:

i) hospitals or facilities operated by the Employer;

ii) as part of such activities that arise as part of the employment contract (e.g. home visits), in colocated private hospitals on public hospital campuses;

iii) in locations outside the public hospital campus, subject to the Consultant fully discharging his/her aggregate 37-hour weekly standard commitment as required by the Employer.

b) The volume of private practice as described at (a) i) and ii) may not exceed 20% of the Consultant's clinical workload in any of his or her clinical activities, including in-patient, day-patient and out-patient.

c) With respect to Emergency and Outpatient Departments specifically, the Consultant shall not charge private fees in respect of:

i) patients attending Emergency Departments in public hospitals;
or
ii) patients attending Public Outpatient Services in public hospitals.

d) A common waiting list operated by the public hospital will apply to both public and private patients undergoing diagnostic investigations, tests and procedures (including radiology and laboratory procedures) on an out-patient basis in public hospitals (including referrals from General Practitioners). Status on the common waiting list will be determined by clinical need only. The list will be subject to clinical validation by the relevant Clinical Director.

The Consultant may charge private fees in relation to private patients undergoing diagnostic investigations, tests and procedures on an outpatient basis subject to:

i) the common waiting list provisions described above;

ii) all billing being processed by the Consultant in a manner that is satisfactory to the hospital and in the event that insufficient information is available for verification purposes recourse may be had to the measures provided for at Section 20 (d) and (e);

iii) the volume of such private practice not exceeding 20%.

e) The Consultant may charge private fees in relation to diagnostic investigations, tests and procedures (including radiology and laboratory procedures) referred to the public hospital by private hospitals, private clinics or other sources outside of the public health system but only where all arrangements for such referrals are effected through the Employer.

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

The HSE may specify additional bodies dealing with public patients or aspects of the public health system to which this provision will also apply. The use of public facilities for all such activities is subject to the prior agreement of the Employer.

R12 - RWP

{In Archive} Consultant Contract Types - minor update

Teresa Cody to: Paula Smeaton 21/11/2017 19:57

Cc: Joanne Lonergan, Sorcha Murray, Paddy Barrett, Lindsey Maidment

Archive: This message is being viewed in an archive.

Paula - I've made a small change to the 1 pager.

The only change is to the last line to clarify that attached is copy of Section 20 of the Contract regarding regulation of private practice and Section 21 which describes the contract types.

Sorry for any inconvenience.

Regards,
Teresa

Consultant Contract Types.revised.docx

----- Forwarded by Teresa Cody/SLAINTE on 21/11/2017 19:53 -----

From: Teresa Cody/SLAINTE
To: Paula Smeaton/SLAINTE@SLAINTE
Cc: Lindsey Maidment/SLAINTE@SLAINTE, Sorcha Murray/SLAINTE@SLAINTE, paddy_barrett@health.gov.ie, Joanne Lonergan/SLAINTE@SLAINTE
Date: 21/11/2017 18:55
Subject: Re: Fw: Paula, could you request a one pager for Minister setting out types of consultant contracts asap please? Thanks, Jo

---

Paula

1 pager with additional explanatory material is attached.

Teresa

Teresa Cody, Assistant Secretary, National HR Division, Department of Health, Dublin DO2 VW90

Paula Smeaton | Can someone pl provide asap - as per above. Ma... | 21/11/2017 18:11:55

From: Paula Smeaton/SLAINTE
To: Sorcha Murray/SLAINTE@SLAINTE, Lindsey Maidment/SLAINTE@SLAINTE, Teresa Cody/SLAINTE@SLAINTE
Date: 21/11/2017 18:11
Subject: Fw: Paula, could you request a one pager for Minister setting out types of consultant contracts asap please? Thanks, Jo

---

Can someone pl provide asap - as per above.

Many thanks

Paula Smeaton
Private Secretary to Minister Simon Harris T.D.
Department of Health

Consultant Contract Types

The Contract allows consultants engage in differing levels of private practice, depending on the contract type held.

Consultants holding a Type A contract are not permitted to engage in privately remunerated professional practice.

Consultants holding a Type B contract may undertake private practice on-site, up to a limit of 20% of activity on a casemix-adjusted basis, and limited off-site private practice in cases where the individual consultant previously held a Category I or Category II contract under Consultant Contract 1997.

Serving consultants whose public to private ratio in 2006 was greater than 20% are permitted to retain this higher ratio, subject to an overriding maximum ratio of 70:30%.

Consultants holding a B* (Star) Contract or a Type C Contract may engage in off-site private practice. Their in-patient and out-patient private practice activity in the public hospital is subject to the 20% maximum limit.

There are 3,189 consultants in the Irish healthcare system of which 17% hold Category A contracts, 58% hold Category B, and the remainder are category B* - 10%, category C - 5%, or 1997 Category 1 and 2 consultants - 10%.

Attached is copy of Section 20 of the Contract regarding regulation of private practice and Section 21 which describes the contract types.

National HR Unit
21 November 2017

20. Regulation of private practice

a) Subject to the provisions of this section, the Consultant may engage in privately remunerated professional medical/dental practice as determined by his or her Contract Type as described at Section 21 below.

b) The volume of private practice may not exceed 20% of the Consultant's workload in any of his or her clinical activities, including in-patient, day-patient and out-patient.

c) The volume of practice shall refer to patient throughput adjusted for complexity through the medium of the Casemix system.

d) The 80:20 ratio of public to private practice will be implemented through the Clinical Directorate structure. The Employer has full authority to take all necessary steps to ensure that for each element of a Consultant's practice, s(he) shall not exceed the agreed ratio.

e) The Consultant will be advised on a timely basis 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 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.

f) The Clinical Director may exercise some discretion in dealing with the implementation of the ratio either for an individual or a group of Consultants once the overall ratio in relation to the particular clinical activity is satisfied.

g) The implementation of the 80:20 ratio of public to private practice shall be the subject of audit including audit by the Department of Health and Children.

21. Contract Type

Consultant Contract Type A

a) A Consultant holding Contract Type A may engage in professional medical/dental practice exclusively for the public Employer(s) or as provided for at (c) below.

b) A Consultant holding Contract Type A shall not engage in privately remunerated professional medical/dental practice. (S)He can only be remunerated for professional medical practice by way of salary as an employee under this contract or as provided for in (c) below.

c) Professional medical/dental practice carried out for or on behalf of the Mental Health Commission, the Coroner, other Irish statutory bodies[1], 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.

[1] An indicative list of such bodies is available from the HSE Employers Agency, 63-64 Adelaide Road, Dublin 2, tel: 01 6626966, web: www.hseea.ie

The HSE may specify additional bodies[12] dealing with public patients or aspects of the public health system to which this provision will also apply. The use of public facilities for all such activities is subject to the prior agreement of the Employer.

Consultant Contract Type B

a) A Consultant holding Contract Type B may engage in privately remunerated professional medical/dental practice only in hospitals or facilities operated by the Employer, as part of such activities that arise as part of the employment contract (e.g. home visits), colocated private hospitals on public hospital campuses and as described at (b) below.

b) A Consultant holding Contract Type B who previously held a Category I or Category II Contract under the Consultants Contract 1997 may continue to hold the right to engage in privately remunerated professional medical/dental practice in locations outside the public hospital campus, subject to the Consultant fully discharging his/her aggregate 37-hour weekly standard commitment as required by the Employer and such private practice being commensurate with the entitlement to off-site private practice held by a Category I Consultant under the Consultants Contract 1997[2];

c) Where a Consultant holding Contract Type B cannot be provided with facilities on the hospital campus for outpatient private practice the Employer shall make provision for such facilities off-campus, on an interim basis, pending provision of on-campus facilities.

d) The volume of private practice as described at (a) and (c) may not exceed 20% of the Consultant's clinical workload in any of his or her clinical activities, including in-patient, day-patient and out-patient.

e) With respect to Emergency and Outpatient Departments specifically, the Consultant shall not charge private fees in respect of:

   i) patients attending Emergency Departments in public hospitals;
   or
   ii) patients attending Public Outpatient Services in public hospitals.

f) A common waiting list operated by the public hospital will apply to both public and private patients undergoing diagnostic investigations, tests and procedures (including radiology and laboratory procedures) on an out-patient basis in public hospitals (including referrals from General Practitioners). Status on the common waiting list will be determined by clinical need only. The list will be subject to clinical validation by the relevant Clinical Director.

   The Consultant may charge private fees in relation to private patients undergoing diagnostic investigations, tests and procedures on an outpatient basis subject to:

   i) the common waiting list provisions described above;

   ii) all billing being processed by the Consultant in a manner that is satisfactory to the hospital and in the event that insufficient information is available for verification

[2] Sections 2.9.4 to 2.9.7 inclusive of the Memorandum of Agreement attached to the Consultants Contract 1997 refer. These are attached at Appendix V.

purposes recourse may be had to the measures provided for at Section 20 (d) and (e);

iii) the volume of such private practice not exceeding 20%.

g) The Consultant may charge private fees in relation to diagnostic investigations, tests and procedures (including radiology and laboratory procedures) referred to the public hospital by private hospitals, private clinics or other sources outside of the public health system but only where all arrangements for such referrals are effected through the Employer.

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

The HSE may specify additional bodies dealing with public patients or aspects of the public health system to which this provision will also apply. The use of public facilities for all such activities is subject to the prior agreement of the Employer.

Consultant Contract Type B*

h) Contract Type B* is immediately available to:

i) A Consultant who held a Category II Contract under the Consultants Contract 1997; subject to the Consultant fully discharging his/her aggregate 37-hour weekly standard commitment as required by the Employer.

ii) A Consultant who held a Category I or II Contract as a Consultant in Emergency Medicine under the Consultants Contract 1997, subject to the Consultant fully discharging his/her aggregate 37-hour weekly standard commitment as required by the Employer.

b) A Consultant who held a Category I Contract under the Consultants Contract 1997 may apply to change Contract Type to Contract Type B* two years after taking up Contract Type A or B.

c) A Consultant holding Contract Type B* may engage in privately remunerated professional medical/dental practice in:

i) hospitals or facilities operated by the Employer;

ii) as part of such activities that arise as part of the employment contract (e.g. home visits), and/or in colocated private hospitals on public hospital campuses;

iii) in locations outside the public hospital campus, subject to such private practice being:

(1) commensurate with the entitlement to off-site private practice of a Category II Consultant under the Consultants Contract 1997; and
(2) confined to periods outside the aggregate 37 hour weekly commitment and other scheduled commitments to the public service.

d) The volume of private practice as described at (c) i) and ii) may not exceed 20% of the Consultant's clinical workload in any of his or her clinical activities, including in-patient, day-patient and out-patient.

e) With respect to Emergency and Outpatient Departments specifically, the Consultant shall not charge private fees in respect of:

i) patients attending Emergency Departments in public hospitals,

or

ii) patients attending Public Outpatient Services in public hospitals.

f) A common waiting list operated by the public hospital will apply to both public and private patients undergoing diagnostic investigations, tests and procedures (including radiology and laboratory procedures) on an out-patient basis in public hospitals (including referrals from General Practitioners). Status on the common waiting list will be determined by clinical need only. The list will be subject to clinical validation by the relevant Clinical Director.

The Consultant may charge private fees in relation to private patients undergoing diagnostic investigations, tests and procedures on an outpatient basis subject to:

i) the common waiting list provisions described above;

ii) all billing being processed by the Consultant in a manner that is satisfactory to the hospital and in the event that insufficient information is available for verification purposes recourse may be had to the measures provided for at Section 20 (d) and (e);

iii) the volume of such private practice not exceeding 20%.

g) The Consultant may charge private fees in relation to diagnostic investigations, tests and procedures (including radiology and laboratory procedures) referred to the public hospital by private hospitals, private clinics or other sources outside of the public health system but only where all arrangements for such referrals are effected through the Employer.

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

The HSE may specify additional bodies dealing with public patients or aspects of the public health system to which this provision will also apply. The use of public facilities for all such activities is subject to the prior agreement of the Employer.

Consultant Contract Type C

a) A Consultant holding Contract Type C may engage in privately remunerated professional medical/dental practice in:

i) hospitals or facilities operated by the Employer;

ii) as part of such activities that arise as part of the employment contract (e.g. home visits), in colocated private hospitals on public hospital campuses;

iii) in locations outside the public hospital campus, subject to the Consultant fully discharging his/her aggregate 37-hour weekly standard commitment as required by the Employer.

b) The volume of private practice as described at (a) i) and ii) may not exceed 20% of the Consultant's clinical workload in any of his or her clinical activities, including in-patient, day-patient and out-patient.

c) With respect to Emergency and Outpatient Departments specifically, the Consultant shall not charge private fees in respect of:

i) patients attending Emergency Departments in public hospitals;
or
ii) patients attending Public Outpatient Services in public hospitals.

d) A common waiting list operated by the public hospital will apply to both public and private patients undergoing diagnostic investigations, tests and procedures (including radiology and laboratory procedures) on an out-patient basis in public hospitals (including referrals from General Practitioners). Status on the common waiting list will be determined by clinical need only. The list will be subject to clinical validation by the relevant Clinical Director.

The Consultant may charge private fees in relation to private patients undergoing diagnostic investigations, tests and procedures on an outpatient basis subject to:

i) the common waiting list provisions described above;

ii) all billing being processed by the Consultant in a manner that is satisfactory to the hospital and in the event that insufficient information is available for verification purposes recourse may be had to the measures provided for at Section 20 (d) and (e);

iii) the volume of such private practice not exceeding 20%.

e) The Consultant may charge private fees in relation to diagnostic investigations, tests and procedures (including radiology and laboratory procedures) referred to the public hospital by private hospitals, private clinics or other sources outside of the public health system but only where all arrangements for such referrals are effected through the Employer.

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

The HSE may specify additional bodies dealing with public patients or aspects of the public health system to which this provision will also apply. The use of public facilities for all such activities is subject to the prior agreement of the Employer.

Teresa JL 28/11

R13-RWD

Thanks. the final proposed letter should be cleared with Minister (Copy to advisers). The response to the HSE document should be by way of a separate letter — also to be cleared with Min. PB 28/11

Secretary General

Consultant Contract Compliance, in particular provisions relating to private practice

On 17th July 2017 (Tab A) the HSE were asked to take the necessary steps to ensure that all consultants are reminded of their contractual obligations in relation to private practice and that processes are in place to ensure these obligations are fulfilled. The DG was also asked to take appropriate corrective action to ensure that anyone considered to be non-compliant adjusts their practice to ensure they fully meet the requirements of their contracts.

The HSE responded on 25th September 2017 (Tab B) stating that:

(i) consultant contract compliance remains a matter of high priority for the HSE within its performance management framework;

(ii) responsibility for monitoring compliance has been devolved to the Hospital Groups but it remains an agenda item at monthly performance meetings held by the HSE Acute Hospitals Division with the Hospital Groups; and

(iii) that the National Director, Acute Hospitals Division has reminded the Groups to ensure that consultants are aware of their contractual obligations and that processes in place locally are observed.

The HSE also provided a draft paper setting out their view of challenges associated with oversight of private practice. The issues raised in that paper should not affect the implementation of measures required to ensure robust governance and monitoring of compliance with the contractual provisions applicable to consultants engaging in private practice with remedial action pursued where breaches are identified.

Draft response to the HSE is now attached for your consideration (Tab C). This has been updated to take account of the Minister's response to the RTE Investigates programme. Also attached is draft response to the broader issues which the HSE raised in their paper. Earlier drafts were seen by Greg Dempsey, Fergal Goodman and Tracey Conroy.

Submitted, please.

Teresa Cody
Assistant Secretary
National HR Division

24 November 2017

SECRETARY GENERAL'S OFFICE
Ref No:
Tracked By:
Date: 27/11/2017

Out JL 28/11/17

R/4 RwP 29/11/17

Consultant Contract - draft correspondence with HSE

Teresa Cody to: Paula Smeaton 29/11/2017 13:35

Cc: Joanne Lonergan, KathyAnn Barrett, James Breslin, secgen, Sorcha Murray, Paddy Barrett, Lindsey Maidment

Paula,

Further to briefing note provided to the Minister last week re the Consultant Contract issues, I now attach draft letters for issue to the Director General of the HSE under the Secretary General's signature. These are in response to the DG's letter of 25th September and have been updated to take account of the Minister's response to the RTE Investigates programme.

Both draft letters are referred for the Minister's approval before issue.

I would appreciate it if you would bring these papers to the Minister's attention.

Letter to Director General 29 November.docx

Comments on HSE policy paper on private practice. v3_29 Nov.docx

Thanks,
Teresa

Teresa Cody, Assistant Secretary, National HR Division, Department of Health, Dublin DO2 VW90

----- Forwarded by Teresa Cody/SLAINTE on 29/11/2017 13:24 -----

Briefing note for the Minister -

Note for the Minister re Consultant Contract Compliance. 21 Nov 2017- final.docx

Sec Gen's letter of 17th July to the HSE Consultants compliance with terms of contracts.pdf

Tab B - HSE response dated 25th September :

- jim Breslin Sec Gen from Tony O'Brien re Consultants complying with terms of their contracts etc 25.09.17 DG Ref 457409.pdf

R15 - RWD

November, 2017

Mr Tony O'Brien
Director General
Health Service Executive
Dr Steevens' Hospital
Dublin 8

Re: Consultants complying with terms of their Contracts, in particular provisions relating to private practice.

Dear Tony,

I refer to my letter of 17th July 2017 and your reply of 25th September 2017 concerning consultants complying with the provisions of their contracts regarding private practice and the draft paper attached.

The position you outlined in your reply of 25th September is noted: - that responsibility for monitoring compliance has been devolved to the Hospital Groups and that the National Director, Acute Hospitals Division has reminded the Groups to ensure that consultants are aware of their contractual obligations and that processes in place are observed.

Nevertheless, it would appear that the arrangements in place are not robust enough to deliver compliance and that some consultants are able to engage in private practice activity at levels that significantly exceed the permitted levels or to engage in significant levels of off-site private practice where their contracts do not provide for same. This has been highlighted by the recent RTE Investigates programme.

It is essential that robust arrangements are put in place to actively monitor compliance with the provisions of the contract by all consultants and to ensure corrective action is taken where any breaches are identified through the monitoring process. I request that a comprehensive framework, operating at both national and local levels, be developed which ensures the

HSE's responsibilities as employer and funder are discharged in line with relevant legislation and contractual provisions.

A non-exhaustive set of options that could be explored to ensure a robust and credible approach include:-

- the auditing of individual hospitals returns and pursuit of corrective action;
- reconsideration of the decision to devolve the responsibility for monitoring and the putting in place of suitable organisational arrangements to deliver a robust compliance framework on an on-going basis;
- consideration of a programme of audit to be undertaken by the HSE's Internal Audit function;
- clarity as to arrangements for confirmation of time and attendance;
- clarity as to individual Consultant assignments and work schedules in accordance with the Clinical Directorate Service Plan, monthly monitoring of same and implementation of any required corrective action;
- specification of personal responsibilities and accountabilities.

Irrespective of whether it is determined that monitoring and enforcement is best pursued at Hospital Group or National level, it is essential that a governance framework and related reporting and monitoring arrangements are put in place in respect of each consultant to ensure that they deliver their work commitment to the public system, that their private practice activity is in accordance with the levels permitted by their contracts and, where this is not the case, that the framework provides for the taking of corrective action. Whereas, in line with arrangements for all employees, there must be local management systems to ensure contract compliance and ongoing performance, the implications for equity and public accountability are such as to require that governance arrangements allow for monitoring at both Hospital Group and National level so that action under the HSE's Performance and Accountability Framework can be assured.

I am also seeking confirmation of the steps the HSE is taking to investigate the apparent breaches of the contract by individual consultants highlighted by the recent RTE Investigates programme.

The Department has given consideration to the broader issues raised in the draft Paper submitted with your letter of 25th September and will be providing you with an initial response separately. However, it is not considered that the issues raised should affect the implementation of measures required to ensure robust governance and monitoring of compliance with the contractual provisions applicable to consultants engaging in private practice with remedial action pursued where breaches are identified.

I would be grateful if you could revert by Wednesday 6th December 2017 outlining the measures being put in place to ensure compliance by consultants with the private practice provisions of their contracts and the steps taken to investigate apparent breaches by individual consultants.

Yours sincerely

Jim Breslin
Secretary General

RISA RWD

An Roinn Sláinte
DEPARTMENT OF HEALTH

Oifig an Ard Rúnaí
Office of the
Secretary General

1 December, 2017

Mr Tony O'Brien
Director General
Health Service Executive
Dr Steevens' Hospital
Dublin 8

Re: Consultants complying with terms of their Contracts, in particular provisions relating to private practice.

Dear Tony,

I refer to my letter of 17th July 2017 and your reply of 25th September 2017 concerning consultants complying with the provisions of their contracts regarding private practice and the draft paper attached.

The position you outlined in your reply of 25th September is noted: - that responsibility for monitoring compliance has been devolved to the Hospital Groups and that the National Director, Acute Hospitals Division has reminded the Groups to ensure that consultants are aware of their contractual obligations and that processes in place are observed.

Nevertheless, it would appear that the arrangements in place are not robust enough to deliver compliance and that some consultants are able to engage in private practice activity at levels that significantly exceed the permitted levels or to engage in significant levels of off-site private practice where their contracts do not provide for same. This has been highlighted by the recent RTE Investigates programme.

It is essential that robust arrangements are put in place to actively monitor compliance with the provisions of the contract by all consultants and to ensure corrective action is taken where any breaches are identified through the monitoring process. I request that a comprehensive framework, operating at both national and local levels, be developed which ensures the

HSE's responsibilities as employer and funder are discharged in line with relevant legislation and contractual provisions.

A non-exhaustive set of options that could be explored to ensure a robust and credible approach include:-

- review of individual Consultant private practice ratios and implementation of measures to ensure contractual compliance;
- clarity as to individual Consultant assignments and work schedules in accordance with the Clinical Directorate Service Plan, monthly monitoring of same and implementation of any required corrective action;
- specification of personal responsibilities and accountabilities;
- the auditing of individual hospitals returns and determination of corrective action;
- strengthening of organisational arrangements to deliver a robust compliance framework on an on-going basis;
- reconsideration of the decision to devolve the responsibility for monitoring compliance;
- consideration of a programme of audit to be undertaken by the HSE's Internal Audit function.

Irrespective of whether it is determined that monitoring and enforcement is best pursued at Hospital Group or National level, it is essential that a governance framework and related reporting and monitoring arrangements are put in place in respect of each consultant to ensure that they deliver their work commitment to the public system, that their private practice activity is in accordance with the levels permitted by their contracts and, where this is not the case, that the framework provides for the taking of corrective action. Whereas, in line with arrangements for all employees, there must be local management systems to ensure contract compliance and ongoing performance, the implications for equity and public accountability are such as to require that governance arrangements allow for monitoring at both Hospital Group and National level so that action under the HSE's Performance and Accountability Framework can be assured.

I am also seeking confirmation of the steps the HSE is taking to investigate the apparent breaches of the contract by individual consultants highlighted by the recent RTE Investigates programme.

The Department has given consideration to the broader issues raised in the draft Paper submitted with your letter of 25th September and will be providing you with an initial response separately. However, it is not considered that the issues raised should affect the implementation of measures required to ensure robust governance and monitoring of compliance with the contractual provisions applicable to consultants engaging in private practice with remedial action pursued where breaches are identified.

I would be grateful if you could revert as soon as possible to urgently outline the measures being put in place to ensure compliance by consultants with the private practice provisions of their contracts and the steps taken to investigate apparent breaches by individual consultants.

Yours sincerely

Jim Breslin
Secretary General

R16-AR

R17 R

{In Archive} Re: Consultant Contract - draft correspondence with HSE - confirmation seen by Min Harris

Teresa Cody to: Paula Smeaton 29/11/2017 19:33
Cc: Sorcha Murray, Paddy Barrett, Lindsey Maidment
Archive: This message is being viewed in an archive.

Thanks Paula.

Teresa Cody, Assistant Secretary, National HR Division. Department of Health, Dublin DO2 VW90
h.gov.ie

Designated Public Official under the Regulation of Lobbying Act, 2015

Paula Smeaton	Yes Teresa - Minister is in agreement with letters...	29/11/2017 19:07:28

From: Paula Smeaton/SLAINTE
To: Teresa Cody/SLAINTE@SLAINTE
Cc: Sorcha Murray/SLAINTE@SLAINTE, Paddy Barrett/SLAINTE@SLAINTE, Lindsey Maidment/SLAINTE@SLAINTE
Date: 29/11/2017 19:07
Subject: Re: Consultant Contract - draft correspondence with HSE - confirmation seen by Min Harris

Yes Teresa -

Minister is in agreement with letters issuing as drafted.

Thanks

Paula Smeaton
Private Secretary to Minister Simon Harris T.D.
Department of Health
Hawkins House
Dublin 2

Teresa Cody	Paula - thanks for this. Can you also confirm that...	29/11/2017 19:04:45

From: Teresa Cody/SLAINTE
To: Paula Smeaton/SLAINTE@SLAINTE
Cc: Sorcha Murray/SLAINTE@SLAINTE, Paddy Barrett/SLAINTE@SLAINTE, Lindsey Maidment/SLAINTE@SLAINTE
Date: 29/11/2017 19:04
Subject: Re: Consultant Contract - draft correspondence with HSE - confirmation seen by Min Harris

Paula - thanks for this.

Can you also confirm that the Minister is satisfied that the letters should issue as drafted.

Regards,
Teresa

Teresa Cody, Assistant Secretary, National HR Division, Department of Health, Dublin DO2 VW90

Designated Public Official under the Regulation of Lobbying Act, 2015

Paula Smeaton	Teresa & others, PI see attached which confirms...	29/11/2017 18:03:45

From: Paula Smeaton/SLAINTE
To: Teresa Cody/SLAINTE@SLAINTE, Sorcha Murray/SLAINTE@SLAINTE, Paddy Barrett/SLAINTE@SLAINTE, Lindsey Maidment/SLAINTE@SLAINTE
Date: 29/11/2017 18:03
Subject: Consultant Contract - draft correspondence with HSE - confirmation seen by Min Harris

Teresa & others,

PI see attached which confirms Minister has seen all attached documents.

[attachment "20171129185642032.pdf" deleted by Teresa Cody/SLAINTE]

Regards

Paula Smeaton
Private Secretary to Minister Simon Harris T.D.
Department of Health
Hawkins House
Dublin 2

Teresa Cody	Paula, Further to briefing note provided to the Min...	29/11/2017 13:35:26

Minister for Health *Government of Ireland*

Simon Harris TD

R18 – R

Ms Cody
1) Letter to DG for my signature
2) Draft letter to Deputy
Mags 08/12/17

For the direct attention of the Sec. Gen.

Hi Jim,

Please see attached.

Can you ensure this is sent to the HSE + investigated in full.

Can you also draft a letter to Dep. Shortall for my signature.

Thanks, Simon

Department of Health, Hawkins House, Hawkins Street D02 VW 90
Tel +353-1-6354148 E-mail ministersoffice@health.gov.ie

R19 - R

RTÉ Investigates Data
Roisin Shortall to: Simon Harris 07/12/2017 12:57

From: Roisin Shortall/Members/Oireachtas
To: Simon Harris/Members/Oireachtas@HOUSES,

Follow Up: Low Priority.

Dear Minister,

Further to my comments last night regarding the recent RTÉ Investigates programme on non-compliance with the terms of the Consultants Contract, I now include a programme summary which was circulated to the media. My concern is that you mentioned at the recent meeting of the Health Committee that you would be investigating the cases highlighted in the programme, however, these were merely samples of what is clearly a wide-spread problem in certain areas of the country, in certain hospitals and in certain specialties.

I trust that there will be a full investigation of this malpractice which is impacting so negatively on the public hospital system.

Regards

Róisín Shortall TD

Summary of Sample data

From our investigative research, based on representative samples of consultants on Type B*, C and Cat 2 consultants (who represent 22% of acute hospital consultants and aregenerally the more senior), we found that over half were doing a level of private work which is incompatible with their public contracts & employment law obligations.

We took samples of full time HSE consultants in busy areas with long waiting lists – Ear, Nose & Throat (ENT, orthopaedics and Galway University hospital).

(a) ENT – out of a sample of 24 of full time HSE consultants on flexible contracts, we found three-quarters doing private work incompatible with their contracts (11 worked between 1.5/2 days privately, with 7 working 2 & half or three days).

(b) Ortho – out of a sample of 31 orthopaedic full time HSE consultants on flexible contracts – we found over half doing private work incompatible with their contracts, (i.e. 13 consultants work between a day a-half & two days privately elsewhere; with 5 working above 2 days ..).

(c) Galway UH – out of a sample of 36 consultants at Galway UH – we found the vast majority (80%) doing private work incompatible with their contracts (i.e. 15 of consultants work a day a-half & upto 2 days privately elsewhere; With further 14 working 2 days or more..)

Public v Private: the Battle for Care

RTÉ Investigates has found a failure by the HSE and hospital managements to properly implement the 2008 Hospital Consultants' Contract across acute public hospitals. Just over 2700 consultants work in 47 acute public hospitals across the country.

As well as being full time HSE consultants, they are also, very unusually for a public system, permitted to do extra paid private work within our public hospitals. On top of that, some consultants are also entitled to work in other private hospitals & clinics.

The 2008 contract provided significant pay increases to consultants in return for agreeing to limit their private practice. Under the deal most consultants are contracted to work 39 hours per week in the public system (other consultants who remained on the old contract stayed on 37 hours).

Today salaries range from one hundred and thirteen thousand to two hundred and twenty-nine thousand euro and that is before on-call & other allowances are added in.

In the main consultants and the hospital, they work in are supposed to adhere to an 80% public patient and 20% private patient breakdown. However, our research shows that failure to enforce the contract is resulting in 14 out of the 47 acute public hospitals exceeding the 20% limit at the expense of public patients.

The figures nationally show the 80/20 ratio is being met however these figures mask the fact that the ratio target is only being met because some hospitals do exceptionally well when it comes to public patients and carry out very little private work.

However, when it comes to regional hospitals it is a different story. A sizeable number of regional hospitals are significantly off target and this is having an impact on public patients.

Data obtained by RTE Investigates also found that while some hospitals were compliant with the public private mix, individual departments within these hospitals exceeded of the 20% private ratio.

All in all, this meant in 2015, the number of private patients treated in these public hospitals in excess of the 20% ratio was over nineteen and half thousand.

Last year the excess number increased to almost twenty-four thousand. That's a total of over forty-three and a half thousand public patients on waiting lists that lost out to private patients in the 2-year period.

Previously the HSE routinely published data on compliance with private practice limits, however when RTE Investigates sought the latest figures the HSE said it no longer kept national figures. In fact, in 2014 it stopped gathering the information outright.

Until now there has been no information available about how many consultants work solely with public patients & how many there are on different contract types.

However, Under Freedom of Information, for the first time we gained access to the HSE's information on consultants' contract types.

We can reveal, that in fact only 6% of all consultants treat public patients only - on a type A contract.

This HSE Information also shows that 66% of all consultants are on what's known as 'Type

B' contracts.

Under the contract, they were granted increases in salary - for limiting the amount of private work they do. Crucially the HSE expected this private work to be done in public hospitals or rooms close by.

Our research also found that some of these HSE consultants are working in private hospitals away from the public hospitals they are contracted to, again at the expense of public patients. We found almost one in three of these consultants advertising their services in private facilities - either in consultant owned clinics on campus and others many kilometres in other private hospitals.

Another group of consultants on more flexible contracts, (Type B*, C and Catetory 2 consultants) are permitted to to work in private facilities on the strict basis they complete their contracted public hours over a minimum 4 days per week.

We also found a number of these consultants doing a level of private work which meant that they were working significantly fewer hours at public hospitals than they were contracted to do, while still being paid a full time salary for their public work.

In one case a consultant we observed for 8 weeks was working less than 13 hours per week in the public system. Based on HSE salary scales, over the 8 weeks, we estimate this consultant was paid over fourteen thousand Euro, for work he didn't do. He was not the only one.

Main Finding 1 - Lack of compliance with private practice limits within public hospitals

1. We found a lack of enforcement of the Consultants' Contract 2008 when it comes to controlling consultants private practice ratios across the hospital system.

2. However record keeping is very poor. The HSE stopped collecting data nationally in 2014 and through repeated FOI requested we got piecemeal records for 20 hospitals up to last year.

3. They show there are problems - at hospital level and in some hospitals where we got more specific data - at medical dept level.

4. The lack of compliance in a significant minority of hospitals - approx 14 out of 47, means there is excessive private practice there.

So although nationally hospital elective figures meet the government target of 80:20% - this masks a problem in hospitals at regional level.

For example, the Mercy in Cork it had 43% elective private patients (day cases and inpatients), St John's Limerick 38%.etc (See Table 1)

Table 1 - HSE Elective discharge data of private patients (Inpatient & Day case) 2016

Hospital	Extra privates	Private rate
The Mercy	5744	43%
St John's	1271	38%
Croom	1272	37%
Mallow	767	35%
UH Limerick	732	34%
South Infirmary	5237	33%
Coombe	4750	32%
Portiuncula	926	29%
Roscommon	432	26%
Nenagh	451	26%
Cappagh	461	25%
St James'	2210	24%
Crumlin	366	22%
RV Eye & Ear	191	22%
Total extra privates	**23,928**	

5. These HSE figures (Table 1) on elective private patients show that in 2016 there was an excess of 23,928 private patients, who were called for procedures/treatment in public hospitals. Similar figures for 2015, show there were 19,648 excess elective private patients.

6. This means that over two years (2015/2016) there was a total of 43.6 thousand private elective patients who had hospital

procedures and treatments, which should have gone to public patients, had those hospitals stayed within the government policy private practice limit (of 20%).

7. From overall discharge hospital figures (HSE's monthly Management Data reports - Dec 2016 and 2015), we also verified that the hospitals listed in Table 1, were also over 20% for all discharges. So they are above the government 20% private practice.

8. In both 2016 and 2015, these private patients displaced 29% or almost one third of public patients on day case and inpatient waiting lists in each year. In December 2016, those waiting for daycase or inpatient procedures was 81,015 (NTPF). In December 2015, those waiting was 68,086.* (Note - those waiting are not necessarily at the hospitals with the excess private, but they are within the same hospital groups).

9. This effect on local services across hospitals is not apparent from national figures which show overall hospitals treat a balance of 80:20% - public to private patients. This is because some hospitals are highly compliant (& have mostly public patients) & other hospitals have large ED admissions (mostly public). This masks problems in at medical dept & at whosle hospital level in other hospitals.

HIPE data

This discharge data is consistent with the findings of poor compliance with private practice ratios by consultants within our hospitals - when the data was being collected.

HSE National office stopped collecting it in 2014. It is held at hospital level but record keeping is patchy and there is little active monitoring ongoing, as per the contract, i.e. notices going out to consultants going above private practice levels.

HIPE data is used as part of a process to measure compliance. It is the

'raw data' on public and private patients treated. But there can be a reason in time why consultants can go over private practice limits. They are given 9 months to balance out their ratios.

Compliance at hospital level measures only certain consultants (those on Type B, B* & C contracts). Cat 1 & 2 consultants under the 1997 contract also had private practice entitlements - their limit is based on private bed numbers, generally 20%.

The HIPE we hold

- All hospitals 2011 (Q2) - 2014 (Q1) (this has been transferred into Table 1 with highest to lowest compliance levels)
- Released by HSE under FOI

Table 2: The average quarterly percentage over three years - from (Q2) 2011 to (Q1) 2014

Hospital	Numbers of consultant overall	Numbers of cons measured (B, B* &C)	% outside contract inpatient	% outside contract daycases	
Croom	8	6	80.00%	56.39%	
UH Limerick	100	77	77.10%	39.98%	
Mallow General	16	8	59.58%	59.58%	
St. Johns	46	4	55.56%	52.61%	
Cork UH	201	159	55.00%	50.09%	
St Luke's – Kilkenny	21	14	53.73%	15.95%	
Midland RH-Tullamore	34	18	51.68%	34.70%	
Tallaght Hospital	131	90	48.94%	24.87%	
South Tipperary General Hospital	20	16	46.93%	14.88%	
Kerry General	39	20	45.67%	16.69%	
Portiuncula					

Hospital	23	9	42.48%	49.68%	
Waterford Regional	48	47	41.23%	38.44%	
Kilcreene	7	7	41.19%	50.35%	

Other HIPE we hold - Approx 20 hospitals with sporadic data post 2014-2016.(this confirmed that levels of non-compliance above, however some hospitals improved some worsened).

HIPE - the three reasons -for non implementation by management

1. 2014 -stopped gathering the data at national level - no oversight
2. 2013 - Health Amendment Act 2013 law came into effect in Jan 2014 - hospitals could bill for all private patients in hospitals - not those in private beds only. This 'allegedly' incentivised management to use private patients insurance cover and also to stop monitoring consultant compliance. (Although a 2017 Dept of Health report shows that by looking at the period since the legislative change, over all private discharge rates did not increase.)
3. Government imposed 'Stretch targets' (ca 2015? onwards) - put even more pressure on hospital managements to raise private revenue from privately insured patients.

Main finding 2 - Lack of compliance with consultants restrictions on private practice done outside the public hospital.

We found a general lack of compliance with the Consultants' Contract in limiting private practice which is carried out by HSE consultants outside the public hospitals.

1. **Only 6% of all consultants working in acute public hospitals are on**

what's known as 'public only' contracts (Type A contracts) - and commit to treating only public patients within those hospitals. (i.e. this means that all patients are treated as public once they are in a public hospital system).

2. 94% of all consultants are entitled do a mix of public and private practice, during the working week.

3. 66% of all consultants are on Type B contracts. These consultants were given enhanced salaries for accepting a strict limit on their private practice, i.e. it's supposed limited to 20% of all their work within public hospitals and for more senior consultants 30%.

The original idea was these consultants would do this limited private practice (surgical/medical inpatients & daycases, outpatients) *within public hospitals,* but this has not happened.

Overtime, contractual exceptions have been used by consultants with the agreement of hospital managements, to allow Type B consultants to do private *outpatient work* in other private clinics and hospitals, both on the public hospital campus and off it.

4. **In practice, almost one third (30%) of these Type B consultants are advertised as seeing private oupatients in other private clinics and hospitals during the working week.** This work is unmeasured by HSE hospital management, eventhough it is supposed to be strictly limited and restricted to outside of public working hours.

5. 15% advertise in consultant owned private clinics on campus; and 15% advertise in other private hospitals, sometimes many kilometres away from the public hospital.

The problem with this is that, while private outpatient work in clinics on campus is *exceptionally* allowed in the contract, it creates difficulties for good hospital management since management is supposed to be able to rely on service of these consultants at all times, for urgent cases and emergencies in the public hospital.

The second problem is that this work is unmeasured despite a contractual restriction that it is supposed to be strictly limited to 20% of a consultants outpatient work, and done outside of public working hours.

According to National HSE, the 2008 contract - and the HSE management guidance issued after it - explicitly ruled out any Type B

contract holder working in private hospitals and clinics away from the public hospital.

This is because of the difficulty in having these consultants return to the public hospital in a timely manner when needed, which they are contractually obliged to do. Despite this, we found 15% of Type B consultants, working in private hospitals across the state, including the Mater Private hospitals, the Beacon, the Bons Secours hospitals etc. Most were doing outpatient work only, but a minority of whom were doing additional surgical and emergency work while in these private hospitals.

Other Type Bs see private outpatients in rooms, near the public hospital which they are contractually entitled to do. These are not counted in the 30% figure.

The consultant representative groups say that this has arisen because of the failure of government to deliver on the policy of co-location, i.e. the building of private hospitals on public hospitals grounds, something which was govt policy in 2008 and is mentioned in the contract. HSE hospital management admit also that they have failed to provide private rooms in many public hospitals - something envisaged by the contract.

6. 24% (or one in four) of acute hospital consultants are on 'flexible contracts', ie those which allow unlimited work in private hospitals or clinics (Type B*, C & Cat 2 (old 1997 contract)

The Type B* and C - these contracts allow consultants to do unlimited private practice in other hospitals and clinics as long, as they are doing their full public hours in the public hospital. (Type B* were offered to more senior consultants, who were in situ in 2008; Type Cs were offered to those with exclusive specialist skills; and 'Cat 2' were consultants who did not take up the new contract but stayed on the old one (i.e. 1997 contract). Cat 2 consultants have the same private practice entitlement as the B* and C, but are also allowed in private practice private hospitals etc, once public hours are worked).

The private work allowed includes surgery - during the working week, once their public work is done.

The HSE guidance on how consultants work their 37 or 39 public hours

is that they are worked over a four day (and part of a fifth day.

7. **From our investigative research, based on representative samples of these consultants, we found that over half were doing a level of private work which is incompatible with their public contracts & employment law obligations.**

We took samples of full time HSE consultants in busy areas with long waiting lists - Ear, Nose & Throat (ENT, orthopaedics and Galway University hospital).

(a) ENT - out of a sample of 24 of full time HSE consultants on flexible contracts - we found **three-quarters - doing private work incompatible with their contracts** (11 worked between 1.5/2 days privately, with 7 working 2 & half or three days).

(b) Ortho - out of a sample of 31 orthopaedic full time HSE consultants on flexible contracts - we found **over half doing private work incompatible with their contracts**, (i.e. 13 consultants work between a day a-half & two days privately elsewhere; with 5 working above 2 days ..).

(c) Galway UH - out of a sample of 36 consultants at Galway UH - we found the **vast majority (80%) doing private work incompatible with their contracts** (i.e. 15 of consultants work a day a-half & upto 2 days privately elsewhere; With further 14 working 2 days or more..)

Background information -

There are 2,706 HSE consultants working across 47 acute public.

They majority work on contract terms dating from 2008, a minority still work on an older contract, 1997.

The Consultants' Contract 2008 -

The contract was agreed offered to Consultants in 2008 after many years of negotiations between the Department of Health (and later the HSE) and the Consultants' representative bodies, the IHCA and the IMO.

Although the same general terms of employment applied to all HSE

consultants were included in the main contract , there were *four* contract types offered - Type A, Type B, Type C & Type B* - with differentiations in relation to private practice entitlements.

Over all discharge data

The most recently available report is the HSE's *Management Data Report*, June 2017 (here compared with June 2016), 'Inpatient and Day Case profiles' show a wide regional variation in public-private mix. These 10 hospitals show private inpatient discharge rates close to/above 30% (there are a further 14 hospitals above 20%). Some showing a clearer problem at inpatient level than at day case level.

Table 3 - overall discharge data, which includes emergency and elective admission. The most recent MDR for June 2017 compared with the year previously shows the following -

	Inpatient private discharges %	Inpatient discharges %	% Elective	Day case Discharges %	Day case discharges
Hospital	June 2016	June 2017	2016/17	June 2016	June 2017
Croom	53	53	75/77	28	29
UH Limerick	33	32	14/12	31	30
Louth GH	36	15	100	15	11
Mallow	28	32	8/10	35	33
Mercy	32	33	21/23	42	43
Nat Mat H	37	33	20/22	21	18
Nenagh	32	23	23/9	23	24
RV Eye & Ear	38	39	70/72	19	18
S. Infirmary	42	43	82/79	30	31
Tallaght (children's)	34	29	9/14	22	20

When you factor in that these hospital level discharge figures (i.e. discharges by all consultants), include Type As (who treat all patients -

even private ones - as public) and old contract holders (Cat 1 & 2), then it is possible to conclude that private discharge rates for the consultants who are measured (Type B, B* and Cs) is higher than the figures indicate.

Table 1 - shown earlier above - excludes emergency admissions.

Other issues

Hospital Capacity/ bed closures/ consultant numbers - vacant posts

Private insurance cover

This is only partially relevant given that insurance cover was at similar rates (but even higher) when the Consultants Contract was agreed, and when government policy re-affirmed, ie. that public hospitals reflect a 80:20 public-private mix.

Some however do argue that insurance cover - and the fact that the national rate is at 45/46% - explains or excuses high levels of private patients within public hospitals.

Reasons why it 80:20% is reasonable, despite private insurance levels:

(a) There are 19 private hospitals and proliferation of private clinics. It is important to note that the private hospital system is undercapacity - as shown by the vast numbers referred there on an ongoing basis through the NTPF;

(b) the contract provides you can still admit/treat a private patient above the limit, but they are dealt with as a public patient;

(c) there is nine month corrective period to re-balance ratios to accommodate busy periods of private admissions; and

(d) the contract obligation of 80:20 is a *percentage* obligation, this means that after busy periods of private admissions/treatments, the consultant must ensure to increase productivity on the public site (according to Prof Drumm, former HSE CEO, the whole point of stating

the obligation in percentage terms, `was to drive public productivity.)

Health Insurance (Amendment) Bill 2017 [Seanad]: Second Stage (Resumed) (Continued)

Message from Select Committee

Dáil Éireann Debate
Unrevised

Wednesday, 6 December 2017

(Speaker Continuing)

[Deputy Róisín Shortall:] Obviously, over recent years, many gave it up. During the austerity years, the level of cover went down to its lowest and it is gradually creeping up again, with 46% of people currently having it. As I said to the Minister last week, I would see this 46% who feel that they must have private health insurance out of fear and out of a lack of confidence in the public health system as a serious indictment of the health system. This is unheard of in most other European countries. Generally, in European countries, people have access to an affordable public health system that is generally free or almost free at the point of use and that is the kind of system we should have in this country. It is the kind of system that Irish people should be entitled to. Unfortunately, we are in a situation where nearly half the population feel they must fork out for very expensive insurance.

I spoke last week about the average premium. I do not accept the average premium figures provided. The average premium for a person over 50 on the basic plan B is €2,000 this year. It had been €1,500 last year. That has to be seen for what it is. It is essentially another tax for people. It is an additional tax of €38 a week or €167 per month to buy private health insurance. If the recent budget had announced the introduction of new taxes of €167 a month, the Government would be laughed out of it, but somehow people seem to think it is all right to put this kind of charge or tax on people just to access basic health cover. Of course, what people get from the basic plan B is basic health cover. It really only enables people to skip the queue and jump ahead of others who do not have private health insurance when it comes to elective surgery.

By and large, the health insurance policies that are available in this country give poor value for money. In addition to paying that €2,000 a year for private health insurance, people are also caught with paying usually the full cost of a GP. A consultant can cost €220 and a person enjoys little cover from his or her health insurance for that. Private health insurance does not cover medicines. In the main, it does not cover any diagnostics. It also does not cover emergency department access. No doubt people are being ripped off. They are faced with this considerable additional bill just so that they can have some

peace of mind that if they have an emergency, or not so much have an emergency but need elective surgery, they will be able to access that in a timely way.

As I said, we are having the wrong debate here. The debate we need to be having is how we move from the current dysfunctional, unfair, inequitable and inefficient two-tier health system to a single-tier public health system comparable to most other countries. That is what all of the emphasis should be on at this point. If the Minister ever needed proof that the present system is so wrong, all he need do is look at the "RTÉ Investigates" programme to see the kind of carry-on there and the blatant abuse of the two-tier system. I suppose events have overtaken that shocking programme but we still need answers to what Deputy Harris, as Minister, will do about the revelations shown in that programme. At the recent Joint Committee on Health, the Minister spoke about pursing the cases that were highlighted in that programme, but of course the fact is that this is a systemic problem in many parts of the country, in particular in hospitals. I will undertake to send on to the Minister tomorrow details of that information that was drawn up by the "RTÉ Investigates" programme.

Deputy Simon Harris: I thank Deputy Shortall.

Deputy Róisín Shortall: They only covered the surveillance of a small number of consultants but the reality is that there are large numbers of consultants abusing the system like this and really gaming the system. That has to be dealt with. We are not getting good value for the significant spend that the taxpayer makes on health, nor are we getting value for money in any way, whether it is in the public system or the private system, and that must be addressed.

Are we on time, a Cheann Comhairle?

An Ceann Comhairle: We are out of time but we might conclude. Does the Deputy have much further to go?

Deputy Róisín Shortall: I am happy to conclude my comments.

An Ceann Comhairle: Perhaps we might ask the Minister to respond.

Deputy Róisín Shortall: The bigger picture has to be addressed because it is not sustainable.

Minister for Health (Deputy Simon Harris): I thank Deputies for their support for this Bill and their contributions to the debate.

I agree with Deputy Shortall, in terms of the debate that we need to be having and, indeed, the debate we are having. This is obviously annual legislation we deal with but the Deputy is quite correct. We have all subscribed in this House to the idea of creating a universal health care system that can provide timely access for patients based on need, not ability to pay. That is where I want to get to as well. In that regard, Deputy Shortall has shown leadership with the Sláintecare report on which I look forward to working with Deputies in this House.

To recap briefly, the main purpose of this Bill is to specify the revised risk equalisation credits and the corresponding stamp duty levies to apply on health insurance from April of next year. I am pleased that this year it has been possible to maintain the main stamp duty at the existing level. In addition, the stamp duty for non-advanced contracts is being reduced by 20%. The credits and levy rates for next year strike a fair balance between the

need to sustain community rating by keeping health insurance affordable for older less healthy consumers and maintaining the sustainability of the market by keeping younger healthier customers in the market.

The Bill also makes a number of changes to the operation of the lifetime community rating to ensure the continued smooth operation of that scheme in a fair and balanced manner. Following enactment of this Bill, I will make a regulation next year which will set out specific details of the changes and will further enhance the operation of the lifetime community rating scheme. These changes, coupled with ongoing increases in employment, which is factually a key driver in the demand for health insurance, will support the market and everyone who wishes to purchase private health insurance.

Before concluding, I will briefly respond to a few questions that were raised in this debate. Deputy Kelleher mentioned that the public health system subsidises consultants to do additional work over and above what they are entitled to do. A key objective of the consultant contract of 2008 is to improve access for public patients to public hospital care. The responsibility for reporting individual consultants' compliance with their contract was formally delegated to hospital groups in 2014. However, it appears clear that these arrangements are not robust enough to ensure individual consultant compliance. My Department is working with the HSE to find a solution to ensure compliance is monitored more effectively. I look forward to receiving that detail from Deputy Shortall tomorrow and passing it on to the HSE, and seeking action upon it.

Deputy Boyd Barrett queried whether the report prepared by the Health Insurance Authority, HIA, will be published. I can confirm that the report will be published before Committee Stage takes place.

Deputy Mattie McGrath asked had I met the Health Insurance Authority. I most recently met it on Thursday, 26 October.

Question put and agreed to.

Committee Stage order for Tuesday, 12 December 2017.

Message from Select Committee

An Ceann Comhairle: The Select Committee on Business, Enterprise and Innovation has completed its consideration of the following Estimate for public services for the service of the year ending on 31 December 2017: Vote 32 - Business, Enterprise and Innovation (Supplementary).

The Dáil adjourned at 10.20 p.m. until 10.30 a.m. on Thursday, 7 December 2017.

An Roinn Sláinte
DEPARTMENT OF HEALTH

RX-R

Oifig an Ard Rúnaí
Office of the
Secretary General

12 December, 2017

Mr Tony O'Brien
Director General
Health Service Executive
Dr Steevens' Hospital
Dublin 8

Re: Consultants complying with terms of their Contracts, in particular provisions relating to private practice.

Dear Tony,

I refer to the draft paper attached to your letter of 25th September 2017 re above and set out the Department's observations on the issues raised in that paper. I have written separately to you on 1 December outlining the need for robust procedures to be in place for 2018 to ensure consultant contract compliance. This letter confines itself to a response to the paper you forwarded.

1. Oversight arrangements

The oversight arrangements set out on page 5 of the HSE paper require further elaboration so that there is a comprehensive outline of interventions to date.

The Department notes that the central oversight of individual consultants based on HIPE and the HSE Consultant Contract Implementation Guidance document version IV was devolved to Hospital Group level. The level at which the responsibility is executed is primarily a matter for the HSE to determine so long as there are effective monitoring and assurance arrangements in place given the operational and policy importance of equity objectives and contract compliance. The provisions of the contract and the Guidance document must be fully enforced. In this regard, the Department was in direct communication with the HSE on a number of occasions in relation to concerns regarding compliance at certain sites and in relation to monitoring and pursuit of non-compliance by consultants generally. For example, following correspondence from the Department, the Director General issued clear instructions to relevant health sector management on 10th October 2012 reaffirming the need for individual hospitals and Hospital Groups to ensure full compliance with the terms of consultant contracts.

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The HSE should now set out clearly what intervention has taken place at national, Hospital Group and hospital level to ensure compliance following delegation of responsibility to the Hospital Groups.

2. Current performance – public /private mix.

The overall activity levels provided are noted. While these show that the '80-20' split is largely being met, the figures are at an aggregate level and do not reflect the variances that exist within the consultant cohort, nor do they capture activity outside of the public system.

(i) The statement on page 6 of your document that *the decision to de-designate private beds was aimed at optimising private income and supporting the delivery of accelerated income targets* is not correct. This statement is wrong on both counts.

The primary intention behind de-designation was to provide for compensation for the economic cost of the service provided to private patients. It followed commentary by the Comptroller and Auditor General on the need for improvements in this area.

(ii) It is correct that the contract makes no specific provision for monitoring of off-site private practice. However, as with any employment or contractual relationship, it is necessary to put measures in place to ensure, as far as practicable that there is full compliance with contracts. The HSE should develop and pursue such measures. The contract provides a detailed framework for assigning each consultant's work schedule to deliver the contractual requirements to the public system. Given the details which were broadcast by RTE Investigates on 21 November and the information gleaned in the course of preparations for the legal cases, it is imperative that attendance in accordance with the work schedule is monitored and corrective action taken where necessary.

(iii) It is stated in the HSE paper that *'..There are no mechanisms to allow HSE determine whether consultants have been paid and on how best to align the requirements in relation to income generation'.* However, public hospitals in practice process Private Health Insurance claims and are aware from HIPE whether treatment was provided on a private basis. Where private practice ratios exceed the permitted levels, it is open to the hospital to pursue private practice fees in excess of the ratio in accordance with the contract on the assumption that payment arose. It is for the consultant to confirm no fees were charged for activity beyond the permitted level or to take corrective action to ensure compliance, if payment beyond the permitted level arose. This, however,

should not prevent the hospital from recouping the economic cost of the service in accordance with the regulatory framework for charging.

(iv) It is suggested that there is a "*..Need to review and re-align DoH guidance with eligibility regulations regarding determination of patient status (public/private).*" This may be part of the outcome of the work of the independent expert group examining the impact of separating private practice from the public system. However, for now, the charging of private patients by the hospital and the charging of fees by consultants can be treated as two distinct elements.

(v) It is acknowledged that many consultants do work in excess of 39 hours, as do many senior staff within the HSE and the broader public service. It is also recognised that the IHCA has been actively pursuing payment for structured on-site attendances at week-ends and public holidays. On the other hand, the flexibilities around the working week under the Public Service Agreements support flexible working patterns. The evidence now available indicates that consultant presence on site requires a more robust governance framework. With regard to the provision of facilities off-campus, if it is the case that the employer has to support off-campus facilities, monitoring of the activities and work commitment of the consultants concerned during this time is required.

3. The following sections address the Key Issues highlighted in the HSE paper.

3. 1. Bed Designation

As noted previously, the Department does not share the view in the HSE document that links consultants' private activity to income generation. The 2008 consultant contract predates the 2013 legislation and the Department has laid considerable emphasis on the HSE policing the operation of the public/private ratio in the contract on a consultant-by-consultant basis.

Where certain significant breaches had been identified and the doctor/s concerned had not brought their private patient activity back to the permitted ratio, steps were to be taken to recoup excess private income, in line with the provisions of the contract. This approach would not prevent the hospital collecting income for the designated private bed or more recently the bed occupied by the private patient. Changes in the law regarding the charging of private patients were not intended to enable what might be termed the increased generation of private income beyond what the C&AG had identified as unbillable because of the previous charging rules. Furthermore, it is not the Department's policy that the generation of income should take precedence over ensuring access for public patients within the public health service.

With regard to consultants who continue to hold the 1997 Contract, it is acknowledged that their contract specifically refers to the ratio of public to private stay beds and that the changes made under the Health (Amendment) Act 2013 changed the 'designation' system.

The Department sees merit in the proposal that a Circular be issued to reaffirm that, notwithstanding the legislative change; the "designation ratios" continue to have effect and will give consideration to this matter.

3. 2. Off-site private practice

The Paper states it is fully accepted that the HSE needs to be able to demonstrate appropriate oversight in this area. This acknowledgement is welcomed but needs to be acted upon. It is acknowledged that monitoring and measurement of private activity outside of the public hospital system may be challenging, particularly if it is established the consultant is delivering the hours committed to the public system. Section 30 of the contract – Conflict of Interest/Ethics in Public Office - offers scope to oblige consultants to confirm compliance with the terms of the contract and this should be explored further.

It is not feasible to adopt the proposal put forward to address the matter through the health insurance market.

3. 3. Alleged conflicting private practice requirements

a) *Conflicting policy imperatives*

It is considered to be the job of HSE to manage the scenario described on page 9 of the document. As outlined above, there is no obligation on consultants to raise fees where they have reached their private practice limits.

b) *Collection of accommodation charges*

The rationale for consultant approval is understood to be for the benefit of the insurer, with confirmation for the insurer that the treatment given was appropriate and delivered in the appropriate setting. This could be given irrespective of whether or not the consultant is seeking fees.

c) *Conflict with requirement to ensure equitable treatment*

As outlined above, it is not accepted that the current funding arrangements require consultants to treat more private patients than is permitted within contractual limits. The 2008 consultant contract predates the 2013 legislation and the Department has laid considerable emphasis over an extended timeframe on the HSE policing the operation of the public/private ratio in the contract on a consultant-by-consultant basis.

d) *Proposed approach - DoH work with the HSE, HIA and Insurers to separate the payment of accommodation charges from the consultant's private contractual relationship with the patient*

Given the points made above, the Department sees the immediate priority as being the robust implementation of the existing contractual and policy framework.

The Health Insurance Authority is the independent regulator of the health insurance market - principal functions include providing expert industry advice to the Minister, ensuring compliance with health insurance legislation and advising consumers regarding their rights and about health insurance plans and benefits.

It is not appropriate or feasible for the Health Insurance Authority to require private health insurance companies to take on monitoring responsibilities for consultants engaged in private practice. The Authority has no role in the contractual arrangements of consultants employed by the HSE or the extent to which they are permitted to engage in private practice within the hospital system.

The Department considers that, as the employer, the HSE should develop and implement any provisions deemed necessary to ensure compliance with agreed terms of contracts.

Separate consideration will be given in parallel through the independent expert group to policy development to achieve further improvements in equity and the use of public resources.

3. 4. Type A Consultants – Extent of role in determining status of Patients

The suggestion on page 13 that the Department should formally communicate to the HSE seems appropriate. The Department will issue a formal communication as outlined to reaffirm that the patient chooses to be public or private, while ensuring that Type A consultants do not benefit from fees.

Finally, the issues discussed above underscore my communication of 1 December on the importance of the implementation of measures required to ensure robust governance and monitoring of compliance with the contractual provisions applicable to consultants engaging in private practice with remedial action pursued where breaches are identified.

Yours sincerely

Jim Breslin
Secretary General