Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Health Service Executive,
Parliamentary Affairs Division,
Block D, 2nd floor,
Parkgate Business Centre,
Parkgate Street,
Dublin 8
Tel. (01) 635 2505
Fax (01) 635 2508
Email: ray.mitchell@hse.ie

10th June 2010

Mr. Ted McEnery,
Clerk to the Committee,
Committee of Public Accounts,
Leinster House,
Dublin 2.

Dear Mr. McEnery,

I refer to your correspondence of 10th March 2010 to the CEO, Professor Drumm regarding our attendance at the PAC on 4th March.

As you will be aware we have responded to a number of the issues & I now attach responses to the following two matters.

1. *Irish Hospital Consultants Association Submission*

   Please find attached HSE response to issues raised in IHCA letter of the 3rd March, together with the following attachments:
   - Extracts from the minutes of the Joint Committee on Public Private Mix Measurements
   - Guidance for Hospital Managers, Clinical Directors & Consultants: Key points agreed regarding the measurement system for public/private mix in the consultant contract 2008
   - Treatment of public/private patients – Management guidance

2. *MRI Scanners Galway & Cork*

   MRI Scanner - Galway
   Magnetic Resonance Imagine affords a unique way of looking at internal cross sectional slices of the body without the need to expose the patient to harmful ionising radiation (such as x-rays). The internal images of body parts produced are not unlike an x-ray image but the technique allows a view across the body scanned in sections at pre-determined points.
   MRI scanning has been accepted throughout the world as an invaluable routine diagnostic tool and is now widely accepted among the medical community as a means of tracking disease and planning the treatment of patients.

   A principal advantage of MRI over radiographic imaging methods such as computed tomography (CT) is that it does not use ionizing radiation. Magnetic fields of the strength used in clinical MRI produce no known significant deleterious biological side effects.

MRI is primarily used to identify diseases of the central nervous system, brain, and spine and to detect musculoskeletal disorders. It is also used to view cartilage, tendons and ligaments, making it useful in diagnosing joint abnormalities.

Magnetic Resonance Imagine (MRI) Scanner, Galway University Hospitals
In 2002, Galway University Hospitals' received capital finding for a temporary MRI. A Ministerial Order was enacted to permit the Hospital to charge for the MRI Service. In 2005, a Permanent MRI was purchased and installed and this replaced the temporary machine supplied in 2002.

In 2003, a private concern established the Merlin Park Imaging Centre to address the increasing demand for MRI examinations and leased a site on the grounds of Merlin Park University Hospital. That centre offers both CT and MRI Services. The Galway University Hospital has a Service Level Agreement (SLA) in place with this facility for the provision of CT and MRI services.

The SLA includes the provision of 1300 public CT patients and 200 public MRI patients can be treated at this facility on an annual basis.

The SLA is reviewed on an annual basis.

MRI Scanner, CUH - Cork
In 1994 the Board (Southern Health Board) agreed, following an open tendering process, to contract with Scancor Ltd. for the provision of an MRI service for public patients of the Southern Health Board. Prior to this, patients from the Southern Health Board area had to travel to Beaumont Hospital, Dublin for an MRI scan.

The contract for the provision of MRI services at Cork University Hospital (CUH) has been tendered for on a number of occasions since 1994, the most recent tender taking place in 2005. Following that tender, which was carried out under in accordance with EU procurement requirements, the contract was again awarded to Scancor. The current contract with Scancor expires at the end of 2010; however, the contract does allow for a two year extension of the service level agreement should CUH require to take up this option.

The service provided by Scancor allows for the provision of 50 patient scans per week (2,600 patients per annum).

Scancor Ltd. is a private company run and owned by a group of Consultant Radiologists five of whom are based and work at CUH.

If you require any clarification on this, please do not hesitate to contact me.

Yours sincerely,

Ray Mitchell
Head of Parliamentary Affairs Division

Response to IHCA letter to the PAC – 3rd March 2010

The following is the HSE response to the Irish Hospital Consultant Associations' (IHCA) submission to the Committee regarding public and private medical practice conducted by Consultants employed in the Irish public health service. The response focuses on particular aspects of the IHCA submission.

Service Plan 2010

The Activity targets outlined in the 2010 service plan are based on the resources available to the HSE in the current year and on the rationale that considerable improvements can be made in relation to the number of patients that can be appropriately treated either outside of Acute hospitals entirely or on an ambulatory/day case basis within acute hospitals.

The evidence from our own bed utilisation studies and from high performing hospitals in Ireland and internationally supports this approach overwhelmingly. Hospitals such as the Mater, St James and St Vincent's are consistently achieving high levels of day case activity and the HSE has expectations that other hospitals can achieve similar levels. It should also be noted that the reorientation of health services towards increased care in the community over recent years has coincided with improvements in the appropriate use of services, and in access waiting times and reductions in waiting lists. Further access improvements are targeted by the HSE in the 2010 service plan.

Internationally health systems have improved daycase rates by thinking of day care as the norm for elective surgery and have redesigned their systems accordingly. They have prioritised the use of day surgery units rather than full operating theatres and have at the same time maximised the time for which theatres are used. These systems have also increased pre-assessments for day surgery patients to reduce last minute cancellations. In Ireland, there are significant opportunities to increase daycase rates in the areas of ophthalmology (e.g. undertaking cataract surgeries) and in the area of varicose veins. For example, Beaumont Hospital, AMNCH, and the Regional Hospital Limerick undertaken over 90% of all their elective cases for varicose veins on a daycase basis. In contrast, Mayo, St.Micahels Hospital, Portlaoise and the South Infirmary all have daycase rates of less than 20% for this procedure. The opportunities for such hospitals to improve and move more treatments to day surgery are significant.

The budget reductions quoted in the IHCA correspondence do not take account of the pay cost reductions introduced in 2010 or the reductions in non pay costs arising for example from the reductions in the cost of drugs and medicines negotiated under the pharmacy agreement. Additional income collection is also targeted in 2010, which has a further bearing on the comparison of the funding allocation between 2009 and 2010. While budget allocations for hospitals are reduced, direct comparisons with the 2009 allocations are not valid for the reasons mentioned.

Public private medical practice

As noted in the IHCA submission, the Consultant Contract 2008 sets out the means agreed by health service employers and the IHCA to measure and regulate the public and private activity conducted by Consultants.

Section 20 of Consultant Contract 2008 states:

- 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.

- 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.

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

- 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.

- 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.

- 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.

- 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.

This Contract was agreed by the health employers and medical unions – including the IHCA – in July 2008. It provides for measurement of public and private practice through the medium of the casemix system as agreed with the medical unions.

The casemix system allows the volume of activity to be adjusted for complexity. The requirement is that the Consultant's public and private activity be of equal complexity – thus avoiding a scenario where it would be possible to comply with an 80:20 ratio by conducting complex work privately and less complex procedures publicly or vice versa.

The IHCA submission raises three broad issues regarding the measurement of public and private practice;

Accuracy of data,
Inclusion of non-clinical activities,
Inclusion of clinical activities not captured by casemix.

In relation to the accuracy of data, reports of activity are generated monthly using the agreed system and issued to Consultants setting out the volume of public and private activity. These reports have been issued to individual consultants each month since 2008. If there are accuracy issues on an individual basis, these should be brought to the attention of the Clinical Director and Hospital Manager / CEO. In addition, if there is evidence of lower levels of private practice than indicated in the casemix report, this also should be brought to the attention of the Clinical Director and Hospital Manager / CEO and taken into consideration in determining activity levels and follow up action if necessary.

Regarding the inclusion of non-clinical activities, it is noted that the IHCA attached to their submission a document prepared by PA Consulting entitled 'HSE Medical Consultants Output Ratio Assurance, Review and Recommendations'. This document proposes an approach which was not agreed during the contract negotiations and forms no part of Consultant Contract 2008.

A key reason why the PA document was not agreed was that it proposed measuring the time spent on public and private non-clinical activities and weighting this against public and private clinical activity. Under such an arrangement, a series of telephone calls made regarding a public patient could be weighted against a complex operation conducted on a private patient. A practical issue arose regarding the monitoring of such non-clinical activity that in the view of health employers made such a system inoperable.

It is surprising therefore that the IHCA has furnished the Committee with details of proposals which were not agreed during contract negotiations as part of its rationale for Consultants not complying with the ratio of public and private mix under the agreed measurement system.

The Committee may be aware that an alternative proposal discussed during the contract negotiations was that the eligibility regulations should be amended. At the current time, eligibility regulations (Department of Health and Children Circulars No 1 and No. 5 of 1991) allow Consultants to bill private patients accommodated in designated public beds. It was suggested that one way to ensure compliance with the specified ratio of public to private practice was to amend the eligibility regulations to ensure Consultants could only bill private patients accommodated in designated private beds. This proposal was rejected by the IHCA.

In relation to the inclusion of clinical activities not captured by casemix; following the issue of Consultant Contract 2008, the Joint Public / Private Mix Measurement Committee established by the health employers and medical unions to ensure agreed implementation of this aspect of the Contract circulated a series of guidance documents on the measurement of public and private practice.

Attached to this response are four documents which are relevant in this regard;

- Relevant extracts from the minutes of the Joint Committee on Public Private Mix Measurement.
- Consultant Contract 2008 – Agreed Measurement systems for Public Private mix – 31st July 08 – which set out the agreed approach;
- Guidance Document on the treatment of public and private patients in public hospitals dated 16.09.09.

Taking these factors into account, the position is that Consultants have entered into a contract which limits the level of private practice and upon which the salary level paid to consultants is based. The procedures for measuring private practice and for dealing with excess levels of private practice when it does occur were the subject of extensive discussion and agreement as part of the contract negotiations and are outlined in the contract documentation.

The intention of the HSE is to implement the terms of the contract in a fair and reasonable manner in all cases and to ensure that the objectives of the contract in terms of improving access for public patients are realised in full.

Appendix 1

Extracts from the minutes of the Joint Committee on Public Private Mix Measurement.

(This committee was chaired by Ms. Maureen Lynott, and included representation from the IHCA, IMO, ESRI and HSE).

Inpatients and Day cases

'It was noted that the Committee were in agreement regarding the implementation of the public: private ratio for inpatient and day cases subject to the following two caveats:

(1) The exclusion of non-clinical activity from the public: private ratio – the consultant associations are to seek clarification directly from the Chair of the Consultant Contract negotiations,

(2) The provision of guidelines to facilitate the adjustment / correction of the 2006 ratios if appropriate'.

'The principles for calculating and allocating the CMU's were agreed by the Committee'.

'It was agreed that a process would be put in place whereby a Consultant can revert to the Clinical Director regarding their specific caseload in instances where they consider there is an apparent disparity between established casemix relative values and the perceived medical input'.

Outpatients

'A common registration process would be introduced for both public and private outpatients. Private clinic volumes would be via private clinic input to the hospital PAS system'.

'It was agreed that a new attendance will carry a weighting of 3 times that of a return attendance; this is an interim solution which will be subject to review by the Committee at the end of the year'.

Diagnostics

'It was agreed that the initial measurement system would be based on total volume and will derive the patient status from the PAS system which interfaces with the radiology and laboratory information systems'.

'It was agreed that the Joint Committee would advance the banding issue further at its next meetings'.

Appendix 2

GUIDANCE FOR HOSPITAL MANAGERS, CLINICAL DIRECTORS AND CONSULTANTS:
KEY POINTS AGREED REGARDING THE MEASUREMENT SYSTEMS FOR PUBLIC/PRIVATE MIX IN THE CONSULTANT CONTRACT 2008

Following discussions with the Joint Committee comprising IHCA, IMO, HSE and DoHC representatives, the following are the main features of the 3 measurement systems specified in the new Consultant Contract, effective 1st September 2008 for Inpatients – Outpatients – Diagnostics:

A. GENERAL

1. The role of the Clinical Director is central in applying the measurement systems results and follow up with Consultants; reports will issue monthly to each Consultant and the Clinical Director.

2. Further to the Consultant Contract, 2008, 3 measurement systems (1each for inpatient/day care; outpatient; diagnostics) will be in place and each will be weighted. Initially weighting applies to inpatient/day care activity, with an interim weighting for outpatients by new and return attendances. In time, a more refined weighting will apply to outpatients and diagnostics.

3. An appeals process will be available through the Clinical Director where a Consultant considers the monthly measurement results are inaccurate or inequitable.

4. The systems outlined for 1st September implementation will be subject to review by the Joint Committee, which will act as a reference group forward.

B. INPATIENT AND DAY CASES:

1. The Case Mix System/HIPE will be the basis to report monthly on a case mix adjusted (CMU) basis for inpatient and day cases, by public and private ratio. **All** Consultant encounters in a case will be recorded and reported. The HIPE system will be amended by the ERSI to reflect the categories of Consultant input into each patient case, based on being a primary or secondary Consultant, performing an operation: etc. These categories are included in the explanatory paper enclosed.

2. The 2006 public/private ratio will be the base for individual existing Consultants for their maximum public/private ratio going forward: e.g.

    a. If a Consultant's ratio for 2006 is less than 80/20 (20% max. private), it becomes 80/20 forward.
    b. If a Consultant's ratio is between 80:20 and 70:30 it remains at that individual's specific ratio e.g. 75:25 in 2006 becomes the base ratio going forward.
    c. If the ratio exceeds 30% private, it reverts to 70:30, (30% max. private).
    d. Consultants have expressed concern that the 2006 ratio as the base forward might not be complete in some instances. Further, previously the discharge Consultant only would generally have recorded into the HIPE summary; whereby in the new arrangement all Consultant encounters will be recorded

to accurately reflect Consultant activity. Where a Consultant considers that their 2006 base private/public ratio is not accurate they can:

i. With the Clinical Director's agreement, seek a review at hospital level in which the Consultant provides verification of their private patients in the period; or documentation of public patient volume where this has not been captured on the hospital system. Such reviews would be dealt with pragmatically and fairly; a final fall back position is where a Clinical Director after assessing the verification provided, would propose the individual Consultant base be the 70/30 ratio. The timeframe for raising such instances on the 2006 results with the Clinical Director is 2008 year end; any agreed retrospective amendments will be made then.

ii.

3. The 2006 base data is prepared by the ESRI and distributed to hospitals, encrypted, in parallel with this communication for review by individual Consultants. The communication on the revised HIPE form, and the guidelines for Consultants regarding input, are also enclosed.

4. In instances where there is an apparent disparity between established international casemix values and the perceived medical input, a Consultant can revert to the Clinical Director regarding their specific caseload.

5. The contract specifies the ratio is based on clinical activity solely; it is agreed the measurement will proceed on this basis.

6. It is clearly important, in order to assure accurate and complete monthly reports for Consultant activity, that the HIPE input form is completed fully and on time.

C. OUTPATIENTS:

1. The maximum agreed ratio for Outpatients for existing Consultants is 70:30 (30% max. private).

2. Public and private out-patients will be reported at Consultant level by volume, adjusted for weighting, on a new and return basis. A new attendance will carry 3 times the weight of a return patient. This method will be subject to review at the end of the year to determine its continuing appropriateness or otherwise. A more refined casemix measurement system for outpatients is in process of development.

3. Hospital PAS systems already have the capacity to provide public OPD activity by volume. Private outpatient clinics will interface with PAS to provide private patient activity by volume. It is agreed to operate a Common Registration System for all patients (in public and private clinics) on a public site. Patient input to the PAS system will occur from all private clinics and public clinics, upon the patient attending the hospital; all patients will have a standard hospital number.

4. All patients in public OPD are deemed public patients; no private activity or billing is permitted.

D. DIAGNOSTICS:

1. It is clearly important, in order to assure accurate and complete monthly reports for Consultant activity, that the HIPE input form is completed fully and on time.

2. For radiology and pathology, the initial measurement system will be based on patient volume, public or private status derived from the hospital PAS system which interfaces with the radiology and laboratory information systems.

    a. For radiology: volume and source of referral is available on the radiology information systems.
    b. For pathology, volume is available; amendment will be made to PAS and laboratory systems, to record private patient status.

3. It is acknowledged, that for purposes of measuring activity, a more appropriate weighting/banding system is needed for diagnostics. It is agreed to jointly progress more appropriate weighting / banding systems which are currently used for private billing of insurers; to both public and private patients. An interim method limited to calculating volume and ratio, by public and private activity, will proceed from 1st September; these systems will be amended when agreement is reached on more detailed weighting methods.

The basis for the use of measurement systems in ensuring the agreed public/private ratio is set out at Section 20 of the Consultant Contract 2008.

For additional information or queries, please contact your Clinical Director or Hospital CEO/Manager. Consultants are encouraged to review the accompanying explanatory documentation prior to referring queries.

July 31st 2008

Appendix 3

Public and private patients in Public hospitals

Guidance to health service management on the treatment of public and private patients

16th September 2009

Purpose of guidance

This guidance sets out revised arrangements for the processing and treatment of public and private patients arising from instructions issued by the National Director, National Hospitals Office, Health Service Executive (HSE) and the Department of Health and Children (DoHC). It reflects changes to the interpretation of eligibility legislation and the introduction and enforcement of Consultant Contract 2008.

These arrangements set out to ensure that persons attending public hospitals have access to services on an equitable basis – irrespective of whether they attend as public or private patients.

Please review procedures in your hospital and make any changes necessary to comply with these arrangements.

This guidance builds on and incorporates elements of a range of documentation relating to processing and treatment of public and private patients issued over the past two years. A list of relevant documents is included at Section 12.

Queries in relation to this document should be directed to: John Hennessy, HSE National Hospitals Office at email: john.hennessy@hse.ie or Andrew Condon, HSE Human Resources at email: andrew.condon@hse.ie

Table of Contents

1. Common protocols applying to public and private patients

Common protocols are to be applied to the management of public and private patients referred for outpatient diagnostics or treatment.

Should referrals from General Practitioners be permitted, such referrals must include both public and private patients without differentiation relating to public or private status.

2. Attendances at public and private clinics

Persons referred to Outpatients must be treated as public patients unless they are clearly identified as private on the initial referral documentation. If they are identified as private patients and wish to be treated privately, they must be referred to an appropriate private outpatient clinic.

No private patients may be called to public outpatient clinics.

Patients attending public Outpatient / Emergency Departments must never be asked whether they have private insurance or wish to be treated privately – for any reason.

Consultant Contract 2008 explicitly requires that Consultants do not charge private fees in respect of patients attending Emergency Departments in public hospitals or patients attending Public Outpatient Services in public hospitals. This includes Consultants performing diagnostic investigations or treatment on patients referred from public Outpatient / Emergency Departments.

3. Common Waiting List for Outpatient Diagnostics and Treatment

All patients – public or private – requiring diagnostic or treatment procedures following an outpatient consultation must be placed on a Common Waiting List if there is a waiting period for access to the procedure.

A Common Waiting List is one which includes all patients – irrespective of public or private status – awaiting a particular procedure.

Patients must be called from Common Waiting Lists regardless of public or private status:

i) in order of clinical priority, followed by
ii) length of waiting time.

4. Additional Outpatient Diagnostics / Treatment clinics or sessions

Any outpatient diagnostic or treatment services / sessions / clinics organised to meet demand must be open to both public and private patients called in order of clinical priority and length of waiting time.

Separate outpatient diagnostic or treatment services / sessions / clinics for private patients are not permitted within contracted hours or otherwise.

5. Common Waiting List is also a requirement of Consultant Contract 2008

Section 21 of Consultant Contract 2008 sets out the circumstances under which the Consultants employed under Consultant Contract 2008 may charge private fees in relation to private patients undergoing diagnostic investigations, tests and procedures on an outpatient basis.

These are as follows:

- the volume of such private practice not exceeding the set ratio of public to private practice (a maximum of 30% for existing Consultants in employment when offer of Consultant Contract 2008 was made in July 2008, 20% for new appointees).

- 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) of the Contract. Section 20 (d) notes that 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.

- A common waiting list operated by the public hospital applying 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.

All outpatient diagnostics are included as regards the Common Waiting List. For example, outpatient diagnostic tests and procedures in cardiology, neurophysiology and gastroenterology.

6. Private Outpatient Clinics must be held outside contracted hours

Eligibility regulations give effect to legislation on the extent to which patients may avail of public or private services in the public health system. They are set out in a range of Department of Health Circulars.

These regulations state that private outpatient clinics may be held on the public hospital campus, however, such clinics must be held outside contracted hours.

Section 5 of Department of Health Circular No. 5 of 1991 states:

> "Where there is a waiting list for outpatient treatment there can be no question of the patients being given preferential access to public clinics on the basis that they are private to the Consultant. A Consultant's private outpatients may be treated in a public hospital either:
>
> i) at a public clinic in accordance with their place on the overall waiting list for that clinic;
> ii) or at a time agreed with the hospital authority, outside of the Consultant's public commitment."

7. Recording attendances at Private Outpatient Clinics on-campus

All persons attending private outpatient clinics on the hospital campus must be registered on the hospital information system in the same manner as those attending public outpatient clinics.

8. Each Consultant's entitlement to private practice

Taking account of the sections above, Consultants, depending on Type or Category of Contract may engage in private practice as set out below:

Consultant Contract 2008

i) **Type A Consultants** cannot engage in engage in privately practice. 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 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 out-patient.

OR

b. 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.

[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

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 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 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.

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.

9. Consultant Contract Type A and private patients

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.
>
> Private patients continue to be liable for maintenance / accommodation charges when occupying private or semi-private accommodation."

This statement does not reflect the approach to this issue adopted by the Department of Health and Children since March 2009 and guidance on this issue is amended as set out below.

In line with the legislation relating to health service eligibility and access to public hospital services and related Department of Health Circulars, the determination of the public or private status of a patient must be specified on admission.

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.

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.

A patient identified as a private patient will continue be liable for the fees of all Consultants contractually entitled to charge fees involved in his or her care. The patient is considered to be availing of private Consultant services where available.

Private patients continue to be liable for maintenance / accommodation charges when occupying private or semi-private accommodation.

Consultants holding Contract Type A may treat such private patients although they may not charge fees for such services.

Two examples of how the public and private status of patients is to be 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.

<u>Scenario 2</u>

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 are accommodated in a designated private bed. The patient is transferred to Type A Consultant.

The patient remains private to the hospital if accommodated in a designated private bed 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.

10. Semi-private patients

Where a patient is

i) admitted under a Type B / Type B* / Type C Category I / Category II Consultant;
ii) pays fees to a hospital for the provision of designated private accommodation and other services in addition to statutory charges; and
iii) such fees are retained by the Employer in their entirety rather than being remitted to the Consultant,

then the patient may be considered public to the Consultant. Such patients are termed 'semi-private' in some institutions.

11. Regulation of Public : Private practice under Consultant Contract 2008

Section 20 of the Consultant Contract 2008 deals with the regulation of private practice and the mechanisms for ensuring compliance with the 80:20 / 70:30 ratio of public to private practice.

It should be noted that ratios that differ from 80:20 public to private are held by Consultants in employment when Consultant Contract 2008 was offered in July 2008 and who remain in the post they occupied at that time. Such ratios are not available to any Consultant taking up post under Consultant Contract 2008 since that time.

Section 20 of the Contract provides that the volume of private practice may not exceed the specified ratio in any of the Consultant's clinical activities including inpatient, day-patient and outpatient.

The volume of practice refers to patient throughput adjusted for complexity through the casemix system. It does not include non-clinical activities, nor does it apply to time.

Section 20 of the Contract states that 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.

Other relevant sections include Section 4 b), which states that

> "both the Consultant and the Employer shall co-operate in giving effect to such arrangements as are put into place to verify the delivery of the Consultant's contractual commitments"

and Section 12 l), which requires the Consultant

> "to participate in and facilitate production of all data/information required to validate delivery of duties and functions and inform planning and management of service delivery."

12. Measurement of public and private practice under Consultant Contract 2008

Set out below is a list of key documents relating to the measurement and organisation of Consultant public and private practice:

- Department of Health and Children Circular No.1 of 1991 – recirculated in October 2008;
- Department of Health and Children Circular No.5 of 1991 - recirculated in October 2008;

- Sample Base ESRI template setting out 2006 private practice ratio, issued in August 2008
- HSE HiPE Casemix Unit – Guidance on Measurement of Public Private Mix – issued August 2008
- ESRI Information note on measurement of Inpatient & Daycase Activity – issued on 1st August 2008
- ESRI Explanatory Note on Individual Consultant Report – issued on 1st August 2008
- ESRI Guidance to Consultants on reporting of HIPE Data – issued on 1st September
- 2008
- Consultant Contract 2008 – Agreed Measurement systems for Public Private mix – 31st July 08,
- Consultant Contract 2008 – Management Guidance Vols I (25th July 2008), II (15th August 2008) and III (28th August 2008),
- Guidance on measurement of Outpatient and Diagnostic Activity – 29th September 08
- Template for monthly public private mix measurement report,

Each of these documents has been circulated to Hospital Network Managers in 2008 / 2009 and may be obtained from same or from email: andrew.condon@hse.ie .

13. Measurement of private outpatient activity under Consultant Contract 2008

Should Consultants engage in private outpatient practice on campus such practice will, like all other public or private activities undertaken on the public hospital campus, be subject to measurement as part of the 80:20 / 70:30 ratio of public to private practice under Consultant Contract 2008.

Measurement includes co-located hospitals on campus, private rooms on campus and private clinics on campus – with three exceptions. The exceptions are the private outpatient practice of existing Consultants in private clinics (as of 26th July 2008) on the campus of St James', Beaumont and Cork University Hospital.

14. Aggregation of inpatient, outpatient, daycase and diagnostic data

Appendix VII of Consultant Contract 2008 notes that the:

> "Public Private Mix Measurement Group shall consider whether such activities can be aggregated to form a single 80:20 public:private ratio. However, this is subject to the implementation of Clause 20(b) with effect from 1st September 2008, in the absence of any agreed alternative measurement arrangement by that date." (Appendix VII, Consultant Contract 2008)

Clause 20 b) of Consultant Contract 2008 states that:

> "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." (Section 20, b) Consultant Contract 2008)

The Joint HSE / DoHC / IHCA / IMO Public Private Mix Group considered this issue in detail between July 2008 and January 2009 without reaching agreement. This means that that there should be no aggregation of inpatient, outpatient day-case or diagnostic data and the limit specified by the Contract should continue to apply to each of the Consultant's clinical activities separately.

15. Aggregation of public private mix across multiple sites

Aggregation of the Consultant's public private mix across multiple sites involves combining workload in two or more hospitals for an individual consultant (for example: in a situation whereby a consultant works in a largely elective hospital and a hospital with mostly emergency admissions).

Consultant Contract 2008 is not explicit on this issue and it was therefore considered by the Joint HSE / DoHC / IHCA / IMO Public Private Mix Group during 2009. In July 2009 the Group decided to refer the issue to the Chair of the Contract Implementation Group for a ruling. Further guidance will issue once a resolution has been arrived at. In the meantime, there should be no aggregation of public or private practice across multiple sites.

16. Ensuring compliance with Consultant Contract 2008 re private practice

Section 20 of Consultant Contract 2008 requires that the Consultant 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.

The date of 1st January 2009 is the earliest date that may be used when determining whether a Consultant's practise in excess of the specified ratio.

Should any aspect of a Consultant's practice be in breach of the ratio of public:private practice specified in their contract of employment, he or she should be advised of same by the Clinical Director / Employer.

In any event, the Consultant should receive written notification within at least 1 month of the issue being identified.

The written notification should:

- Note the ratio of public to private practice specified in that Consultant's contract;
- Note the provisions of Section 20 of the Contract;
- State precisely where and to what extent the Consultant's practice is in excess of the specified ratio;
- Request that the Consultant meet with the Clinical Director / Employer to discuss how the matter will be resolved;
- Note that the 6 month period provided for at Section 20 e) of the Contract has now commenced.

Should the matter be resolved within the 6 month period no further action is required.

However, should any aspect of the Consultant's practice continue to be in excess of the specified ratio after 6 months have elapsed, the Consultant should be issued with written notification of same, required to meet with the Clinical Director, Hospital Manager / CEO and other relevant staff and a timetable determined for resolution of the matter within the following three months.

Section 20 provides that if, after a period of 6 months and a further period of 3 months, the appropriate ratio is not established, the Consultant 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. Such fees are likely to be calculated as a proportion of the Consultant's private fees pro-rata to the extent to which the Consultant is in breach of the ratio. Further guidance will issue on this point.

17. Reporting compliance with Consultant Contract 2008

Each Consultant in the employment of the public health service – irrespective of whether they hold Consultant Contract 2008 or not - should be issued with a public private mix measurement report every month. This should document their activity in relation to inpatient, daycase, outpatient and diagnostic activity over the previous three months.

The report is also issued to the relevant Clinical Director and Hospital Manager / CEO for consideration and to facilitate action to ensure with Consultant Contract 2008.

An overall status report is also prepared for internal HSE monitoring and management purposes and monitoring. From the January 2009 reporting period this report is considered

as informing decisions by Clinical Directors and managers on individual Consultant compliance on a contractual basis. It will be provided monthly to the HSE Board, the Department of Health and Children and will be available under FOI.

18. Regulation of Public : Private practice under Consultant Contract 1997

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."

19. Ensuring compliance with Consultant Contract 1997 re private practice

Taking account of the above, should the proportion of private patients treated by a Consultant holding the Consultant Contract 1997 or the Academic Consultant Contract 1998 exceed the ratio of designated private beds, he or she should be advised of same by the Clinical Director / Employer.

In any event, the Consultant should receive written notification within at least 1 month of the issue being identified.

The written notification should:

- Note the ratio of public to private practice specified in that Consultant's contract;
- Note the provisions of Section 2.9.3 of the Consultant Contact 1997 / Academic Consultant Contract 1998;
- State precisely where and to what extent the Consultant's practice is in excess of the specified ratio;
- Request that the Consultant meet with the Clinical Director / Employer to discuss how the matter will be resolved;

Should the matter be resolved within a 6 month period no further action is required.

However, should any aspect of the Consultant's practice continue to be in excess of the specified ratio after 6 months have elapsed, the Consultant should be issued with written notification of same, required to meet with the Clinical Director, Hospital Manager / CEO and other relevant staff and a timetable determined for resolution of the matter within the following three months.

20. Employer to make provision for off-campus facilities for outpatient private practice

Consultant Contract 2008 states (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 nature of such provision is unclear and requires further discussion between health service employers at national level. Pending agreement on same, no local arrangements should be made.

21. Charging for use of public facilities

The Employer should have a policy regarding the use of public facilities by staff pursuing private business interests. While such a policy could provide for charges, the employer should be consistent in its application of charging – it should apply to staff equally and from a set date.