IRISH HOSPITAL CONSULTANTS ASSOCIATION

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Mr. John McGuinness T.D.,
Chairman,
Committee of Public Accounts
Dail Eireann
Kildare Street
Dublin 2

**Subject: 2009 Annual Report of the Comptroller and Auditor General**

Dear Deputy McGuinness,

I refer to the hearing conducted by the Committee of Public Accounts on Thursday, September 29th. I refer in particular to the Committee's examination of Chapter 44 of the Comptroller & Auditor General's Report for 2009

The Committee previously examined matters pertaining to the operation of the Consultant Contract 2008 with specific reference to the public private mix on March 4th, 2010. The Association has not had an opportunity of appearing before the Committee and I trust that you will accept this submission so that members may be more fully briefed when they next consider these matters.

## Public Private Measurement System

**There is a clear difference of opinion within the HSE as to how this measurement system should operate.**

The Comptroller outlined in Section 44.3 of his Report the basis on which a consultant's practice was to be measured for the purpose of this exercise in the following terms:

*"In accordance with the Consultant Contract 2008 the volume of practice is measured on the basis of patient throughput with an adjustment for case complexity based on case mix weightings".* (My emphasis)

The HSE did not dispute the Comptroller's definition at the hearing and I am unaware of any divergence of views otherwise communicated to either the Comptroller or the Committee. We must assume that the HSE now accepts that definition.

Mr Brian Gilroy, National Director, Commercial and Support Services, has a different view. In reply to a question from Deputy Nolan he stated "there are two stages to the process. The first is a HIPE *(Hospital In-Patient Enquiry)* report, the case mix report that is run by the ESRI on behalf of the HSE. That is the system that is in the contract. However, it also states in the Contract that due cognisance is taken of complexity and there are other rule sets in the contract".

The Casemix system does not take account of all patients seen in a hospital.

The National Director's view must be contrasted with the determination of the Comptroller & Auditor General cited above, where the C&AG recognised that volume of practice should be measured on the basis of patient throughput and that the Casemix system is a tool for adjusting for complexity only and does not, as yet, account for all clinical activity.

This Association has always subscribed to the definition expressed by the Comptroller and which now, for the first time in public, appears to be accepted by the Chief Executive Officer of the HSE when he stated '*The measurement system HIPE does not capture all the activity. Putting in the process to recognise that and deal with that at an individual consultant and hospital level has been difficult. We are not saying the measurement system through HIPE is perfect. There are gaps with regard to capturing all the clinical activity.*'

The Association outlined a series of deficiencies in the HIPE System in its previous submission to the Committee, dated March 4th 2010. These deficiencies render it unsuitable for measuring patient throughput. The following extract from our submission may be of assistance to current members:

**'Casemix System**

The Casemix system, also known as the Hospital Inpatient Enquiry (HIPE) System was originally designed as an economic model to aggregate data on hospital activity and costings, to provide a basis for allocating resources to hospitals and to develop service plans. **It was never intended to be used to micro manage the clinical activity of individual consultants.**

The Casemix model analyses the record of each patient discharged from hospital. It records the following information:

Patient name
Case referenced number

Dates of admission and discharge
Dates of first and principal procedure
Day case indicator
Admission type and admission source
Discharge status and discharge destination
GMS Status
Medical card number
*Admitting and Discharge Consultant*
Intensive care days
*Private care days*
*Public care days (optional)*
Infant admission weight
Date of transfer to Pre-Discharge Unit
Admission mode
Waiting list indicator
*Principal and up to 19 secondary diagnoses (ICD-10-AM)*
*Principal and up to 19 secondary procedures (ICD-10-AM)*
Date of birth
Gender
Marital status
Area of residence by county

Those items in *italics* are directly relevant to the public private ratio.

The range of **clinical activities** carried out by individual consultants includes some or all of the following:

*Undertaking a detailed and comprehensive history and examination*
*Pre operative ward rounds to include interval history*
*Operating Theatre*
*Day case surgery*
*Endoscopy sessions*
*Post operative ward rounds*
*Outpatient clinics*
*Sub Specialty Clinics*
*Minor ward rounds*
*Non Interventional radiological examinations and reporting*

*Interventional radiological examinations and reporting*
*Labour / Delivery Ward duties*
*Intensive care ward activity*
*Recalls to problem cases*
*Emergencies during the working day*
*Out of hours emergencies / admissions*
*Pathology studies and reports*
*Post mortem examinations*
*Multi disciplinary team meetings*
*Inter hospital transfer of patients*
*Domiciliary visits*
*Case Management duties*
*Radiation oncology planning and delivery*
*Organ retrieval*

This list is not comprehensive

It is clear that the Casemix system as currently structured does not capture the totality, or in some cases any, of the clinical activity of individual Consultants. For example, none of the activity in Emergency Departments, that are public only facilities, is captured. Last year alone, there were nearly 1.2 million presentations to our Emergency Departments leading to 366,000 admissions. Likewise the clinical work in specialties such as radiology, pathology or anaesthesia is not captured.'

The National Director regards the Casemix system as the sole system for counting patient throughput. Given the Comptroller's and Mr Magee's statements that view is clearly not sustainable. It may also explain the abject failure of the HSE to provide a considered response to our earlier submission to which it had been invited by the previous Chairman of the PAC in March 2010.

I trust the above detailed information will give members of the Committee some insight and understanding why the implementation of these particular provisions of the Contract has proven so bothersome.

## Measuring Consultants Clinical Activity

The Association, for its part, has sought through a Joint (HSE/IHCA/Irish Medical Organisation) Public Private Ratio Working Group to reach agreement with the HSE on the proper operation of the public private element of the Contract. The HSE has steadfastly failed over the past three years to put in place

a system that satisfies the fundamental definition of the measurement system set out by the Comptroller and now acknowledged by the CEO. It is totally unreasonable for the HSE to claim, in those circumstances, that consultants and this Association have not being cooperating.

What is clear is that the HSE is using a measurement system to do a particular job for which it was never designed and has never been properly adapted to undertake. That is a matter for the HSE to appropriately address and in the interim it should not blame others for its own failure to do so.

I might also add that the assertion by the CEO that two Consultants whose rights were suspended did not co-operate is vehemently denied and there is documentary evidence that the opposite is in fact the case.

Particular reference was made to the circumstances of one of two consultants who have had the right to private practice restricted. As was pointed out by Deputy Murphy, the Clinical Director in question confirmed in writing that the consultant was fulfilling the requirements of his contract. This conclusion was arrived after the Clinical Director reviewed the practice of the consultant in question, taking particular account of how public patients are seen and treated by the individual concerned.

The National Director, Commercial and Support Services, claimed that following that review, someone in the HSE concluded there was still a breach. The basis of that conclusion has not been made known to the consultant concerned, nor has the Consultant been given a right of appeal. Such tactics are reprehensible in this day and age. Sceptics might see a correlation between the timing of that decision on September 16th to restrict private practice and the proceedings of your Committee on September 29th.

The actions of the National Director should be examined in the context of his statement made to the Public Accounts Committee. In the course of his submissions, the National Director made the following contribution; "*The purpose of the limit on the public-private ratio was not as a stick to beat people with or the basis for a witch-hunt; it was to create equity of access*" It is clear from that comment that in situations where there is genuine and verifiable equity of access in a clinician's practice that these particular provisions of the contract should not apply. Were they to do so, either those private patients or the HSE (and, by definition, public patients) would be seriously disadvantaged by either delaying treatment of private patients until the ratio was achieved or by treating otherwise private patients as public patients with all costs associated therewith falling on the HSE and thereby depriving the HSE of badly needed revenue and denying other genuine public patients of access to timely care.

In this particular case the Clinical Director satisfied himself very carefully that public patients enjoyed equity of access and on that basis formally wrote that the consultant was complying with the terms of his contract.

The National Director cannot have it both ways. He must either stand by his statement that this system is designed and used to ensure that public patients are not disadvantaged or else confirm it is a stick to beat people with. In the present case it is most definitely being used as a stick to beat a well respected and highly regarded clinician who has tried to do his best for all of his patients. If the National Director was not misleading the Public Accounts Committee, I would expect him to use his good offices to bring this demonization to an end.

## Income Collection

There was considerable discussion on the outstanding sums due to the HSE in respect of maintenance charges for private patients. The sole block identified by the HSE was the treating consultant in respect of one third (in value terms) of those. Bearing in mind that Consultants are also required to sign similar forms in private hospitals and the debtor days in those institutions are considerably less than in the HSE, it is regrettable that the Committee did not probe this further.

Over 70% of admissions to our public hospitals are emergencies. Those patients are treated immediately. Their status may not be notified to the Consultant for some considerable time afterwards.

Consultants themselves have an interest in signing off insurance claim forms. The most common complaint the Association receives from its members is in respect of the delay in having the duly completed claim forms made available to them for signature by the hospital.

Significant parts of the insurance documentation are normally completed by the patient and hospital administration staff. When the patient has been discharged the hospital should collate all the relevant patient notes and records to ensure that clinical component of the form may be filled in by the Consultant and returned by the hospital to the insurers direct payment office for onward processing. Whilst the consultant signature is an important stage in the process there are a significant number of other stages in advance of and subsequent to that where delays can arise.

The Association remains available to the Committee if further clarification is required on these matters.

Yours sincerely

**Donal Duffy**
**Assistant Secretary General**

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