IHCA Presentation by Dr Tom Ryan to the Oireachtas Joint Committee on Health, 13 December 2017.

The IHCA, which represents in excess of 85% of hospital consultants in Ireland, welcomes the opportunity to attend the Committee's discussion on the RTE Prime Time programme aired on 21 November.

With regard to contractual obligations, the Association wishes to be absolutely clear that its consistent stance is that consultants must abide by the conditions of their employment as outlined in the various consultant contracts. Concerning consultants who do not fulfil their contractual hours, it must be clearly understood that any such Consultants are not representative of the profession. The agreed administrative procedures for dealing with such matters are clearly provided for in Consultant contracts. The IHCA is of the view that such matters should be addressed through the contract mechanism by management.

In reality, the vast majority of consultants work well in excess of their contracted hours, in order to care for patients that rely upon an under-resourced and understaffed healthcare system. This has been confirmed since the programme aired by the Minister for Health, Mr Simon Harris, and by Mr Liam Woods, HSE National Director of Acute Hospitals.

As a consequence of our commitment, over the past decade the IHCA and its members, in collaboration with health service management, have delivered significantly increased productivity in the acute hospital system at a time of extraordinary cuts to health sector funding. It is worth considering that, while acute hospital budgets were cut steeply compared with 2008, the total number of inpatient and day-case patients treated has increased by approximately 275,000, or by 22%. In other words, consultants have been instrumental in dramatically increasing productivity in the health sector.

Over this same decade, when our population expanded by 12%, and the cohort aged 65 years and over increased by a third, the number of inpatient acute public hospital beds was reduced by more than 1,400 beds. The result is that our hospitals are almost continuously full with patients. OECD data confirms that they operate at 95% occupancy, which is way above the OECD average of 77%. The OECD average is recommended so as to prioritise consistent safe patient care and to guard against hospital acquired infections.

As a direct result, the average hospital stay in Ireland, at 6.2 days, is much shorter than the OECD average of 8.2 days. Also, Ireland annually hospitalises far fewer patients, at 139 per 1,000 of population, due to overwhelming capacity deficits, than the average OECD country at 169 per 1,000 population.

Department of Health data confirms that hospital consultants make up less than 2.5% of the overall public health service workforce, which contrasts with 4% in the NHS in England. In Scotland, which has a population that is just 13% greater than Ireland's, there are more than 5,000 hospital consultants compared with around 2,600 permanent consultants in post in Ireland. So there are significantly fewer hospital consultants in Ireland on a comparable population basis.

The Association is emphatic that the paucity of hospital beds and the shortages of hospital consultants are the fundamental causes of waiting lists for patients in Ireland.

Department of Health data (2016 Trends in Health) confirms that currently 80% of acute hospital admissions are emergencies and the volume of elective surgery performed in acute public hospitals has progressively declined over the past decade. Accordingly, hospital admission in Ireland is increasingly only feasible for patients with emergency medical and surgical conditions, due to the significant capacity deficits that are increasing year after year.

Against the backdrop of an under-resourced and understaffed public health system, the Association continues to strongly recommend to its members that they report to their relevant Clinical Director, so that they can work in teams

with their clinical colleagues to an agreed practice plan. This is important to provide the best possible patient care, during daytime hours and as part of organised on-call services at night and weekends. The IHCA is strongly of the opinion that the vast majority of consultants work in accordance with an agreed practice plan and are more than fulfilling their contractual hours.

The 2008 contract delegated certain clinical governance roles in the acute hospitals and mental health services to clinical directors. Frequently, however, clinical directors encounter significant difficult in fulfilling their role, as they have not been provided with the necessary support staff and infrastructure.

With regard to the ratio of public and private patients in public hospitals, it was agreed in the 2008 Contract that the ratio should not exceed 80:20 with a provision allowing some consultants a 70:30 ratio. These ratio provisions were incorporated in the 2008 Consultant Contract with a clear reference to the government policy in 2008 that co-located private hospitals would be built on public hospital sites. The government policy committed to putting in place an additional 1,000 such co-located private hospital beds, and furthermore the 2008 Contract explicitly permits hospital consultants to treat patients in co-located hospitals.

However in 2011, the co-location policy was abandoned by the new government, and as a result the additional 1,000 acute hospital beds in co-located private hospitals have not been commissioned. The concomitant closure of a further 1,400 inpatient beds in our acute hospitals have clearly driven the waiting lists to their current levels.

Crucially, it is widely acknowledged that the methods used to measure public to private ratios are both inaccurate and unreliable. This was identified as a problem in an independent management report commissioned by the HSE in 2007 during the Consultant Contract negotiations. In 2011, the IHCA and senior HSE management agreed that those serious flaws in the systems and methodology needed to be rectified, but that has not happened as yet.

The annual revenue from private patients in public hospitals amounts to more than €600 million, or some 15% of the public acute hospital funding, and

higher in some hospitals. The revenue private patients bring to the public hospital is thus an essential source of funding. One should bear in mind that without this revenue our public hospitals would collapse. Public acute hospitals could not deliver the current level of service to the public without this revenue let alone hope to expand or improve the clinical service that we aspire to deliver to our patients.

Health service management and consultants were blamed in a recent RTE programme when the proportion of private patients admitted to public hospitals apparently exceeded 20%. Yet we know from Department of Health data (2016 Trends in Healthcare) that over 80% of patients admitted to acute hospitals are emergencies. Given that more than 45% of the population holds private insurance, and indeed more than 50% of patients in the over 40 age group,. there may be situations where, outside the control of hospital management and consultants, the proportion of private patients attending a public hospital may exceed 20%.

Under these circumstances, blaming hospitals and consultants whenever the ratio of private patients exceeds 20%, is not a reasonable stance to adopt. In effect, such hospitals are blamed for providing care to the cohort of patients who present for care, and which reflects the demographic composition and insurance status of the patients in their catchment area, over which they have no control. Blaming hospitals and consultants for treating patients is unreasonable.

The demand for patient care is increasing due to demographic factors. Indeed a recent ESRI study projected a 37% increase in the need for inpatient and day case capacity by 2030. Yet in contrast there are growing public hospital capacity deficits due to the cumulative lack of investment in hospital infrastructure and equipment over the past decade. This is the root cause of the unacceptable waiting lists in Irish health care. It is a distraction from the reality of the effects of long standing underfunding to blame hospitals and their consultants for current waiting lists, when they are in effect being

prevented from providing timely and appropriate care to patients. Regarding patients on waiting lists, they must be treated according to clinical need.

Lastly, it must be clearly stated that waiting lists will persist while the acute hospitals are underfunded, under-resourced and understaffed. These key issues, which the Association and its members have highlighted over the past decade, in annual pre-budget submissions, must be addressed as a priority for patients. We should not be distracted from the fundamental and overwhelming acute hospital capacity deficits which are preventing consultants and public hospitals from providing timely, safe, high quality care to patients and leading to ever increasing waiting lists.

We thank the Committee for the invitation to attend this session. Our over-riding concerns are that the large capacity deficits in the acute hospital and mental health services, which have led to a predictable steep decline in essential non-emergency surgical and medical care in our hospitals, have not been addressed. This has led to a continuing rise in those waiting on trolleys in emergency departments and in the time patients spend waiting for procedures and operations.

Thank you.

Dr Thomas Ryan, IHCA President