Consultants in Ireland: Time for Decision

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As Britain's National Health Service passes into its 27th year and faces problems which threaten to destroy it the medical profession and, doubtless, the Department of Health in Ireland watch its malaise with concern and interest. Not by any means the least interested are the consultants, who, like their British colleagues, are studying contract options for the future, and many of whom with first-hand experience of working conditions in Britain's N.H.S. would not wish to see it duplicated in this island. Therefore the ultimate consultant contract in Ireland will probably differ substantially from that negotiated by British consultants.

Ireland's Health Service

Though consultants on both sides of the Irish Sea are concerned for their future and are seeking better conditions of service and remuneration the similarity ends there. To begin with, Ireland does not have a comprehensive health service but rather provides a free hospital service for 92% of the population—that is, those whose annual income is under £2250. The remainder pay privately for hospitalization and treatment, mostly through the Voluntary Health Insurance (V.H.I.) Board, a statutory, non-profit organization. In addition 10% of those eligible for free hospital treatment choose to insure privately with the V.H.I., thus giving that organization a total membership of 500 000 subscribers who contribute about £6 million annually.

There is also the general practitioner service, or General Medical Services (G.M.S.), for which only 35% of the population is eligible subject to a rigid means test. Those not covered by the G.M.S. scheme pay for general practitioner attention privately or insure themselves through the V.H.I.

There are roughly speaking three types of consultant in Ireland. Firstly, there are those—the majority—who are employed in voluntary hospitals. They are paid a salary calculated according to bed occupancy (the "pool" system)——£0·69 per day per public inpatient in a general teaching hospital and £0·49 in a general non-teaching hospital—and by sessional payments of £16·45 per three-hour session and pro rata, giving annual salaries of from about £1500 to £6000 according to the commitment, those at the upper end of the scale often being attached to as many as three hospitals. The voluntary hospital consultants depend greatly on private practice, and the above relatively low scales of pay were introduced in 1955 to compensate them for the loss of private practice earnings due to their "honorary" hospital work. They provide their own cover for superannuation and sick leave.

Secondly, there are the consultants employed in area health board hospitals. They are paid a salary of £6845 a year, with provision for superannuation and sick leave, and are allowed a limited amount of private practice. A minority are whole-time consultants with an annual salary which varies somewhat but is about £7500.

Thirdly, there are some consultants without a public hospital appointment who depend solely on private practice and the facilities available in private hospitals, of which there are a number in the major cities. Their incomes vary considerably and, of course, their superannuation and sick leave is not provided for.

Irish consultants will therefore negotiate from a position of partial contract or in most cases no contract, whereas their British colleagues are trying to improve a contract which has existed for many years.

Political Considerations

Both Ireland's Minister of Health and Britain's Secretary of State for Social Services are members of a labour party, Mrs. Barbara Castle belonging to a party which is alone in power whereas Mr. Brendan Corish's party is in coalition with the more conservative Fine Gael party. Both parties to this coalition, though differing on details of administration and finance, are committed to introducing a national health service which would provide free hospital treatment for the whole population,

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regardless of income, and would increase the proportion eligible for the General Medical Services scheme from the present 35% to over 60%. Many would argue that the Minister has his priorities wrong and that he should first try to provide free primary care for all and only then turn to free hospital care.

There is a difference, however subtle, between Irish and British socialism. Mr. Corish has never committed himself to phasing out private practice as Mrs. Castle has done with pay beds. Furthermore, unlike the British, a comparatively large number (18%) of Irish people insure themselves privately—some because they have to, some because of the advantages of private treatment, some because they have been brought up to private practice, and others no doubt because they cannot face the overcrowding and attendant disadvantages of our present health service. Some of these would not take kindly to losing the option of private practice, a point which no political party can ignore. There are good reasons why Mr. Corish should study carefully voluntary forms of health insurance, which should be compatible with and, if properly structured, to the advantage of a national health service.

Mr. Corish, like Mrs. Castle, is faced with the problem of paying for a health service in a time of growing inflation. The financial situation has changed considerably since he first mooted his plans for free hospital treatment in 1973, and the shortage of money is being felt at all levels of hospital administration. Many consultants claim that with the present overcrowding, inadequate facilities, and understaffing priority should not be given to providing free treatment for the wealthy 8% of the population. Some would argue that this would result in further deprivation for the less well-off by adding to the pressures of an already overburdened service and that to persist in it would be merely to follow doctrinaire socialism for the sake of doing so.

Whereas many would agree in principle with a comprehensive national health service, others would argue that Ireland is simply not wealthy enough for such a service. It is indeed debatable whether in an era of unprecedented albeit exorbitantly expensive advances in medicine and allied technology any nation is, or ever again will be, in a position to provide a fully comprehensive health service.

Professional Militancy

In common with Mrs. Castle, Mr. Corish has had to face increasing professional militancy. When he tried in April 1974 to abolish the income ceiling and introduce free hospital treatment for all (and thus theoretically abolish private practice) he was met by determined and united consultants who refused to co-operate without first having adequate time for negotiating conditions of service and methods of remuneration. Mr. Corish, having six months earlier experienced the militancy of the junior hospital doctors (they had actually gone on strike in support of their claim for better pay), postponed free hospital treatment but raised the income level of eligibility from £1600 to £2250 a year.

The consultants, who were then negotiating directly with the Minister and his department, urged that the primary—but not necessarily the only—method of remuneration should be by a schedule of fees. Mr. Corish refused to agree and set up a review body, the Finlay Commission, to report on the conditions of employment and pay of consultants. Both the Irish Medical Association and the Medical Union refused to give evidence to this body on the ground that all relevant evidence had already been submitted directly to the Department of Health. All negotiations between the profession and the Department of Health have since ceased and will not reopen until the review body reports.

In contrast to their British counterparts, Irish consultants are at a considerable advantage in negotiating a de-novo contract. They have studied methods of consultant remuneration in other countries and, furthermore, have seen their general practitioner colleagues negotiate an item-of-service system of payment with fees ranging from £1·18 for a surgery consultation during normal hours to £3·36 for a consultation from midnight to 8 a.m. and a similar scale of fees for domiciliary consultations. The doctors prefer this to the per capita system and patients generally are in accord with it.

So a majority—but by no means a vast majority—of consultants have come to favour remuneration based on a schedule of fees (a system employed in many countries, including most of those in the E.E.C.) as opposed to payment by salary. The Minister of Health, however, favours remuneration by salary with superannuation and sick leave provisions, fearing that a schedule of fees method would be prohibitively expensive and possibly open to abuse.

Unlike Mrs. Castle, Mr. Corish seems willing to allow consultants some private practice. He would permit, and perhaps encourage, the Voluntary Health Insurance to continue a scheme whereby subscribers might meet the difference between public subvention and the full cost of private treatment. The consultants have to consider carefully the effect of a national health service on private practice. Some would argue that over half of the 18% of the population who at present insure privately would continue to do so after the introduction of a national health service and that it was not unreasonable to exchange half their private practice for a good salary with superannuation and sick leave rights.

The Future

Probably there will emerge from discussion a contract giving a choice of two systems of remuneration. One would be a salary for a basic number of hours of work a week together with payment for availability outside working hours and possibly additional payment for work actually done during availability time. There would also be provision for sick leave and superannuation. The other system would be payment according to a schedule of fees with a guaranteed minimum income but probably no provision for superannuation and sick leave.

Varying opinions on the consultants' plight in Britain have been expressed in the *B.M.J.*, and it takes little analytical prowess to conclude that remuneration, while undoubtedly an essential facet of negotiation, is not the prime cause of discontent. The consultants are dismayed and demoralized (for once an apt word) by inadequate working conditions and those with foresight view the future with despair. So, too, in Ireland most consultants think that excessive emphasis has been given to remuneration with too little detailed planning for present and future hospital requirements.

With hospital facilities in Ireland generally inferior to those in England—the truth, however odious, must on occasion be stated plainly—the younger generation of consultants returning from abroad look with horror and incredulity at the total lack of co-ordination in planning within the hospital service and can only wonder if those responsible for policy in the Department of Health are aware of the poor quality of patients' beds, the overcrowding of existing services, the lack of office and secretarial facilities, and the inadequacy of so-called professorial departments in teaching hospitals—to say nothing of the impossibility of obtaining money for staffing service departments and purchasing the most empirical equipment.

Perhaps no government can afford to provide such facilities, but it would be better for future generations of both patients and doctors if this truth were faced up to now so that appropriate alternatives might be explored and implemented. Only by so doing may we hope to establish a health service the ultimate aim of which should be—but now so rarely seems to be—the welfare of the patient.

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