Consultation on Private Practice in Public Hospitals
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to:
IRGPrivatePublic
04/01/2018 11:14
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From: "David Buttimer" [redacted]
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1 Attachment

CONSULTATION ON PRIVATE PRACTICE IN PUBLIC HOSPITALS.docx

Dear Sirs,

I attach a submission on Private Practice in Public Hospitals in response to your advertisements in the Press during December.

I should point out that I am a layman, albeit with training in economics, but have no particular expertise in hospital administration.

Hoping that my comments are helpful,

Yours faithfully,

David Buttimer,

[redacted]

CONSULTATION ON PRIVATE PRACTICE IN PUBLIC HOSPITALS.

The question of how to separate private consultant practice from the public acute hospital system cannot be solved until decisions are made about which services are to be provided through the public hospital system and which through the private hospital system.

Up to now, the public system has tried to supply all specialties and all services to public patients, but it is clear from the waiting lists for some services that the public hospital system does not have the capacity to provide such a wide-ranging service. This is probably due to the higher number of older patients, and the stress that the demand from older patients puts upon the acute hospital service. The consequence of this is that elective surgery and other elective procedures get postponed, and the waiting list for these procedures gets longer and longer. This situation is not going to get better any time soon. In fact, it is likely to get worse as the percentage of older people in the population grows. Therefore, it is time for a re-think about whether the public hospital system should even try to provide a comprehensive service in all specialties to all people.

The function of government is to ensure that all services are supplied to all patients to a high standard in a reasonable time at a reasonable cost, by using ***all the hospital resources in the country***, both public and private, as efficiently as possible. The public service should supply those services which the private hospitals are not able or willing to supply (or are not able or willing to supply in sufficient quantity). The private hospital service should supply those services which the public hospitals cannot supply in sufficient quantity to meet demand. For public patients, the government should pay the bill, wherever the service is supplied, using a mechanism such as the National Treatment Purchase Fund. The patients do not care whether the services are supplied by public hospitals or by private hospitals, provided they are available in a reasonable time.

It is evident from the waiting lists for some specialties, (mainly orthopaedic, eye, e.n.t. and psychiatry) that the public hospitals cannot meet the demand for these services. Therefore, the government has the duty to ensure that they are provided through the private hospitals, and that if there is not sufficient capacity in the combined private and public hospitals to meet the demand in a reasonable time frame, incentives are put in place to induce the private sector to increase the capacity. For most specialties adequate capacity would be forthcoming from the private sector if the government guaranteed that the public sector would not compete for these specialties, and the government would pay for public patients availing of them.

The logic, therefore, is that the public hospitals should withdraw from some services that they currently supply, starting with those services for which the waiting list is the longest. This would have to be done in consultation with the private hospitals and the consultants, both private and public, who currently supply those services, to ensure that adequate total capacity is in place to cope with the demand in each region of the country. If extra private sector capacity has to be put in place to cope with the demand, then the public sector should continue to supply the service for a transition period until the extra private sector facilities are put in place. During this transition period, the public sector consultants should be paid at the same rate per patient as they would be paid in the private sector, so that there is no perverse incentive to treat private versus public patients. It might be advisable to use the transition phase in the public sector to treat only patients who are already on the waiting list, so that new patients enter the private sector queue, and provide an incentive for the private sector to increase capacity as soon as possible.

When the public sector succeeds in exiting a specialty, this should free up space in the public hospital for other services, and perhaps help to reduce the waiting list for them. If the waiting list for any specialty continues to be too long in a particular region, then efforts should be made for the public hospital in that area to exit that specialty too. This process should continue until waiting lists for all specialities in both public and private hospitals are at an acceptable level.

This should not be approached on an ideological basis; there is no reason to believe that any particular specialty would be better provided in the private rather than the public hospital. Different decisions will be made in different regions, based on which specialties have the longest waiting list and which have spare capacity in the private hospitals and consultant availability in the region, or have the best possibility of new capacity being provided in the short to medium term. There will be some cases, e.g. scoliosis, where the best decision may be to increase the capacity in one public hospital to provide a national service available to both public and private patients.

As a consequence of these decisions, private practice will have been removed from the public hospitals in those specialties which the public hospitals have ceased to provide. The loss of income to the public sector from the cessation of private practice in those specialties will be partly compensated by not having to pay salaries to those specialists.

The length of time required to implement these changes will depend on the ability of the private sector to increase capacity in each specialty. In some regions and some specialties, that capacity may already exist. In other regions it may take a few years to get to the stage where the private sector can meet the full demand with a reasonable waiting list. Therefore, the process of change is likely to be gradual, taking several years, which may make the financial management easier.

However, the policy should be focussed on reducing the waiting lists by transferring those specialties with the longest waiting lists to the private hospitals. The separation of private practice from the public hospitals will occur as a result of this policy, *and may not need to be a policy objective at all.* Indeed, it may turn out that in some specialties, the most effective way of keeping the waiting list low is to provide the service to both public and private patients exclusively through the public hospital.

David Buttimer.

4th January 2018