Resolution of issues relating to treatment of private patients in public health services and Consultant private practice

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1. Admission by Type A Consultants reduces patients' rights

a) Summary

Since 2009, arising from an instruction by the Department of Health, patients admitted by Type A Consultants lose the ability to opt for private status on admission or subsequently, in contrast to patients admitted by Consultants holding any other type or category of contract. This has resulted in a loss of private income for hospitals and meant that Type A Consultant posts have not been created in most admitting specialities across the public hospital system. A further issue is that the Department's instruction is conflict with the eligibility regulations set out in Department Circulars arising from the Health (Amendment) Act 1991 and rendered incoherent the regime in place for the treatment of public and private patients in the public hospital system.

b) Background

DoH Circular No 1 of 1991 set out the matters covered in regulations made by the Minister for Health under the Health (Amendment) Act 1991 regarding eligibility for care in public hospitals. The Circular states in regard to 'Determination of public or private status of an in-patient' that:

> "It will be an essential element of the new arrangements that the public or private status of a patient must be specified on admission and the patient identified as a private patient will be liable for the fees of all consultants involved in his or her care. The definition of 'private status' is that the patient is opting to avail of private consultant services rather than the public consultant services available under the Health Act. Membership of a health insurance scheme, does not, of itself, imply private status.
>
> Where a patient is being admitted arising from a private out-patient consultation, it will be presumed that he or she is a private patient unless the patient specifies to the contrary and this is confirmed by the consultant.
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> If a patient admitted in emergency circumstances is unable to opt (or have a relative opt on his or her behalf) for either status but subsequently opts for private status, he or she will be regarded as a private patient from admission and therefore liable for the fees of all Consultants involved in his or her care from admission." (DoH Circular No 1 of 1991, 3)

DoH Circular No. 5 adds the following:

> "However, where a patient remains private to the consultant for the out-patient element of a programme of care which includes both out-patient and in-patient treatment (e.g. obstetrics) the patient is not entitled to opt for public status as an inpatient." (DoH Circular No 5 of 1991, 2, 3)

Taking the above into account and in the absence of any amendments to the regulations or related circulars, 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."

In early 2009 a number of health insurance companies queried whether patients admitted by Type A Consultants could opt to be treated as private patients. The matter was considered by the Department of Health & Children who wrote to the HSE on 23rd March 2009 stating:

> "The position is that a patient may only be regarded as having "private" status where he/she opts to avail of private consultant services rather than public consultant services under the Health Acts. As Category A Consultants do not undertake any private work, there is no basis on which a patient under the care of such a consultant could be accorded "private" status."

c) Issues arising

The effect of the Department's communication referenced above is that 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. In that regard, such patients, if admitted in emergency circumstances and unable to opt for a particular status at the time, lose the ability to do so. In addition, patients undergoing a programme of care which which includes both out-patient and in-patient treatment (e.g. obstetrics) who are private during the out-patient element may subsequently have public status imposed on them if admitted by a Type A Consultant.

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 or may choose to opt for private status at a later stage following admission.

In that context, for patients admitted or treated by Type A Consultants, private status is no longer determined by reference to the source of referral, patient choice or agreement by the Consultant (as per DoH Circulars) but by reference to the contract type held by the individual admitting or treating consultant. In contrast, were the patient to be referred on to a Type B, B*, C, Category I or Category II Consultant, determination of patient status reverts to source of referral.

The interpretation offered by the DoH letter of 23rd March 2009 directly contradicts the provisions of DoH Circulars No 1 and No 5 of 1991 regarding the determination of the public or private status of inpatients and outpatients and introduces a new means of making such a determination.

The effect of the interpretation has been to severely limit the number of Type A posts in specialities outside Psychiatry and Emergency Medicine. Hospitals are acutely aware that the presence of a Type A Consultant on an on-call rota has the effect of converting a mixed stream of public and private patients – some of whom may in normal circumstances be expected to generate private income for the hospital – into a stream of public only patients, without patient consent. In such circumstances hospitals have consistently failed to advance applications for Type A posts.

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

Scenario 2

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 have private health insurance. The patient is transferred to a Type A Consultant. The patient remains private to the hospital as they have private health insurance 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.

d) Arbitration by Mark Connaughton SC

This matter became the subject of arbitration by Mark Connaughton SC has Chair of the Consultant Contract 2008 Implementation Group. Following receipt of submissions on the matter, he wrote to the parties on 26th April 2010 stating:

> "Concern has also been expressed by both Consultant Organisations that there has been an apparent change of approach to the determination of the question, when a person admitted can avail of private care following admission. Reference is made in this regard to the determination by the Department of Health and Children that patients admitted under a Type A Consultant must, throughout their stay, be designated as public patients. Reliance is also placed on what are generally referred to as the *eligibility regulations* comprised in Circular 5 of 1991. It is suggested by both Consultant Organisations that the approach adopted shows considerable inflexibility and does not accord with their understanding throughout the negotiations or indeed, the text of the Circular taken as a whole.
>
> I think there is merit in the argument of both sides on this issue. On the one hand, it is clear that the Regulations have not changed but the direction from the Department of Health and Children to which I refer does appear to have altered the practice.
> It would be wholly unsatisfactory if the essential purpose of the 1991 Regulations was to be frustrated. The element of patient choice must also be respected, as per those regulations. However, it strikes me that further discussions between all of the relevant parties, including the Department of Health and Children, could produce agreement consistent with the essential principles enshrined in the relevant Circular and the Consultant Contract."

e) Proposed approach

It is proposed that the DoH formally communicate to the HSE by way of circular that the approach described in DoH Circulars No 1 and No 5 of 1991 regarding determination of patient status remains in place subject only to amendment arising from regulations issued under the Health (Amendment) Act 2013. This would mean that a single, consistent regime was in place for determination of public or private status irrespective of the contract held by the admitting Consultant. Persons admitted by a Type A Consultant would be able – on referral to a Consultant of a different contract type or category or in relation to private accommodation to opt for private status and would be regarded therefore as private patients from their admission onwards. No fees would accrue to the Type A Consultant in any circumstances. A barrier to the creation of Type A Consultant posts in admitting specialties would be removed and it is anticipated the number of Type A Consultants would grow as a proportion of the Consultant workforce.

2. Addressing off-site private practice which is in breach of contract

a) Background

In the period since 2008 repeated instances of non-compliance with the requirements of Consultant Contract 2008 regarding the location of private practice have been identified. These requirements differ depending on Contract Type. For example, Type A Consultants may not engage in private practice irrespective of location, Type B Consultants who transferred to Consultant Contract 2008 from Consultant Contract 1997 retain access to off-site out-patient private practice but not in private hospitals or clinics. New entrant Type B Consultants (since March 2008) cannot engage in off-site private practice of any kind. Where breaches were identified the issue was often that the employer had either explicitly sanctioned or not taken any action to resolve situations where Type B Consultants were engaged in medical practice in private hospitals or clinics. Often, the option to seek change in Contract type to Type C or Type B* to support contractually compliant offsite private practice had not been initiated. This issue arose in Galway, Limerick and Dublin in particular.

HSE HR has engaged with employers on this issue on a number of occasions. In terms of performance of the Contract, difficulties have included both the extent of sanction by the local employer and the absence of any contractual provision relating to monitoring of such breaches of contract. In simple terms, the control mechanism is after rather than before the breach.

b) Proposed approach

Noting the above, Consultants engaged in offsite private practice obtain a significant volume of their private income via health insurance providers (who reimburse the Consultant for services provided to insured persons). One such health insurer is the VHI, an agency under the aegis of the Department of Health it is proposed that the Department of Health assign the power to the Health Insurance Authority to require health insurers to only reimburse those Consultants who are employees of the public health service where such Consultants have the contractual authority to engage in private practice in public hospitals, private hospitals, private clinics or in any other setting.

This would introduce a regulatory mechanism which would disincentivise Consultants from breach of their public employment contractual commitments.

3. Employers impose conflicting private practice requirements on Consultants

a) Conflicting policy imperatives

A range of policies regarding collection of private income to fund delivery of public hospital services appear to conflict with the need to assure compliance with the public / private practice requirements of Consultant Contract 2008.

Firstly, each year the HSE identifies a private income target for each acute hospital based on the previous year's expenditure. Private income provides funding to meet the difference between funding provided by the Department of Health and actual public hospital expenditure. Targets are set with regard to the capacity of the hospital to generate income and the need to maintain – based on Consultant Contract 2008 - a national ratio of public to private patients at 80/20.

In this regard, the HSE Service Plan 2016 as approved by the Minister for Health requires that acute hospitals private income receipts vary from planned targets by no more than 5% and that measures were taken to promote the improved generation and collection of private charges income within acute hospitals.

In 2016, the HSE has identified a private income funding requirement of approximately €633m.

b) Arrangements for collection of accommodation charges

Secondly, despite attempts to renegotiate the arrangement, private health insurance companies link payment of the accommodation charge to the hospital to the separate claim for a clinical treatment or procedure. This means that hospitals can only receive payment for use of a bed by a private patient where the treating Consultant has confirmed that they treated the patient privately.

In this context, the September 2012 'Consultants Implementing the Public Service Agreement' document set out the following:

> "vii) Timely and efficient management of private patients
>
> Consultant facilitation and implementation of measures to support collection of income arising from the treatment of private patients in public hospitals, including:
>
> a. A commitment from all Consultants to fully complete and sign private insurance forms within 14 days of receipt of all the relevant documentation. The purpose of this provision is to effect a significant reduction in outstanding income due to the public health system. Persistent failure to comply will be addressed by the employer and it is noted that the employer has full authority to take the steps necessary to resolve the matter.
>
> b. Co-operation with the Secondary Consultant scheme whereby a secondary Consultant involved in a case can sign the claim form if the primary consultant has not signed within a reasonable timeframe. The current timeframe in operation with the VHI is claims older than three months. Health service management wish to reduce this and the timeframes

operated by other health insurers to one month and commit to supporting Consultants to achieve their responsibilities in this regard.

c. Co-operation with the implementation of electronic claim preparation and submission in the manner required by the insurer (the HSE has recently awarded a tender for the introduction of an electronic claims management system in eleven of its key hospitals).

d. Co-operate with the implementation of reasonable changes that may be introduced to generate and collect additional income."

c) Conflict with requirement to ensure equitable treatment of public patients in public hospitals

Noting the above, the Consultant Contract 2008 is now the main mechanism giving effect to national policy regarding equitable access for public patients to public inpatient services. Nevertheless, in order for hospitals to secure sufficient accommodation income from private patients to meet expenditure requirements, Consultants are both required and incentivised to treat and charge a particular volume of private patients without reference to contractual limits.

In the face of this potential conflict of interest and as noted previously, the Contract provides Consultants with a number of options. Firstly, they may choose to treat patients in excess of their ratio as public patients. Secondly, they can treat patients privately but not charge. Finally, they can treat patients privately, charge and remit the excess fees to the Research and Study Fund.

There is however no evidence that Consultants make use of these options. Instead some Consultants – and some hospitals – argue that Consultants in settings where a significant proportion of patients attending or referred or private cannot be expected to do anything other than treat attending / referred private patients privately, charge them accordingly and retain the income.

d) Proposed approach

Taking the above into account it is proposed that the Department of Health work with the HSE, the Health Insurance Authority and health insurers to separate the payment of accommodation charges from the Consultant's private contractual relationship with the patient. One way to achieve this would be for the health insurer to receive some form of certification that the accommodation of the patient was medically necessary, perhaps by way of regular independent audit and provision for remittance of payments from the hospital to the insurer if some period of accommodation was found to be unnecessary.

This would have the effect of removing any connection between the hospital collection of private income for patient accommodation and the regulation of Consultant private practice.

4. No limit to inpatient private practice for Consultants on 1997 and 1998 Contracts

a) Legislative changes affecting bed designation

Arising from regulations made by the Minister for Health under the Health (Amendment) Act 2013 changes were made to the charging of patients holding private health insurance in public hospitals. Previously, patients were required to opt for private status and to be accommodated in a designated 'private' bed prior to becoming eligible for an accommodation charge. The changes meant that persons holding private health insurance could be charged irrespective of whether they were accommodated in a private bed or not. Effectively, the distinction between designated 'private', 'public' and 'non-designated' beds and related treatment spaces (such as couches etc) was removed and all beds became chargeable in respect of levies for private accommodation.

While the changes described above are not relevant to the private practice of Consultants holding Consultant Contract 2008 – which regulates private practice by measuring volume of caseload adjusted by complexity of same – they directly affect the extent to which the 365 Consultants on either the 1997 Contract or the 1998 Academic Consultant Contract can engage in private practice.

b) Extract from Consultant Contracts 1997 and 1998

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."

Taking the above into account, all public hospital beds were designated as public, private or non-designated beginning in the early 1990s. The extent to which beds were designated varied significantly – from 45% designated private beds in St John's Hospital, Limerick to less than 10% in St Vincent's University Hospital or the Mater Misericordiae University Hospital.

The effect of the changes introduced under the Health (Amendment) Act 2013 is to allow all public hospital beds to function as designated private beds should they be filled by a patient with private health insurance. In that regard, there is no meaning to the terms 'public bed' or 'private bed'. 100% of public hospital beds now function as designated private beds. This removes any contractual limit on on-site private practice for the 365 Consultants holding the 1997 Consultant Contract or 1998 Academic Consultant Contract.

c) Proposed approach

Noting the above the mechanism for management of private practice under Consultant Contract 1997 is founded on a regulatory regime which has now been amended by legislation. On examination, there appear to three potential approaches:

- The Department of Health issues a circular clarifying the extent to which the regulatory regime (including bed designation) introduced following the Health (Amendment) Act 1991 remains in place. Such a circular would have to confirm that notwithstanding the facility for charging patients with private health insurance irrespective of bed designation introduced under the Health (Amendment) Act 2013 that designated public and private beds / treatment spaces remained in existence.
- An amendment is negotiated between the employers and the medical unions to Consultant Contract 1997. This appears highly unlikely.

Legislation is passed providing for the continued existence of designated beds. This appears to be both a difficult and perhaps unnecessary course if the same action could be achieved by way of circular.

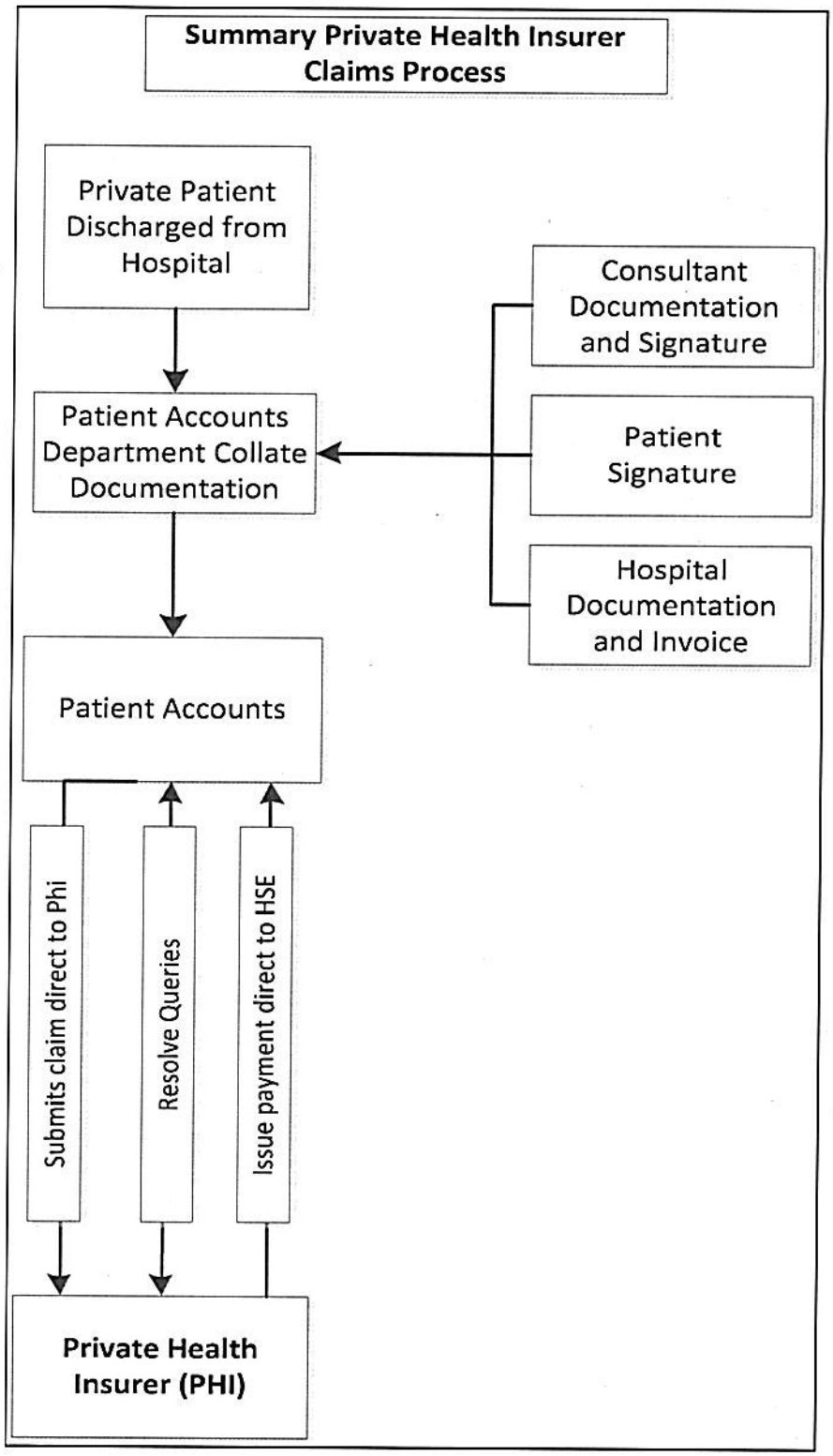
Private Patient Charges

Hospital Category	Single Occupancy Room	Multi Occupancy Room	Day Case
	€	€	€
Hospital specified in the 5th schedule	1,000	813	407
Hospital specified in the 6th schedule	800	659	329

	2014	2015	2016	2017 *
	€'m	€'m	€'m	€'m
Private Patient Income	570.099	615.826	626.277	572.786
* November YTD projected to year end				

Private Patient Income by Hospital and Hospital Group	Hospital Category	2014	2015	2016	2017 *Extrapolation*
Beaumont Hospital	5th Schedule	34,396,860	40,111,396	35,818,478	34,909,220
Our Lady's of Lourdes Hospital, Drogheda	5th Schedule	15,539,874	15,848,034	18,681,206	13,360,278
Connolly Hospital, Blanchardstown	5th Schedule	7,893,485	7,531,757	8,461,214	6,790,513
Cavan Monaghan General Hospital	6th Schedule	7,360,880	7,131,707	6,922,110	6,631,950
Rotunda Hospital	5th Schedule	13,112,137	12,220,131	11,952,319	11,936,054
Louth County Hospital	6th Schedule	541,714	545,024	490,969	381,252
Total RCSI Hospital Group		**78,844,951**	**83,388,049**	**82,326,296**	**74,009,268**
St. James's Hospital	5th Schedule	45,988,000	52,060,000	52,787,000	48,927,022
Adelaide & Meath Hospital, Tallaght Adults	5th Schedule	36,731,524	37,307,545	36,271,345	32,758,515
Midland Regional Hospital, Tullamore	6th Schedule	10,383,231	10,607,077	10,270,157	9,927,500
Naas General Hospital	6th Schedule	4,143,080	6,037,308	6,776,454	5,181,022
Midland Regional Hospital, Portlaoise	6th Schedule	5,655,368	5,735,706	4,907,062	4,908,806
Coombe Women & Infants University Hospital	5th Schedule	12,775,080	10,770,266	12,359,897	11,056,588
St. Lukes Hospital, Rathgar		2,754,747	2,349,707	2,768,496	2,771,200
Total Dublin Midlands Hospital Group		**118,431,030**	**124,867,609**	**126,140,410**	**115,530,652**
Mater Misericordiae University Hospital	5th Schedule	24,886,143	26,503,355	29,995,515	26,364,213
St Vincent's University Hospital, Elm Park	5th Schedule	24,002,998	29,642,468	27,641,030	23,919,103
Midland Regional Hospital, Mullingar	6th Schedule	7,906,214	7,501,302	7,771,124	6,667,177
St. Luke's Hospital, Kilkenny	6th Schedule	8,560,354	9,191,785	9,622,222	9,033,125
Wexford General Hospital	6th Schedule	8,491,420	8,885,233	8,299,426	7,173,795
National Maternity Hospital, Holles Street	5th Schedule	12,975,067	14,486,674	14,032,203	14,840,049
Our Lady's Hospital, Navan	6th Schedule	2,336,797	2,530,958	2,484,772	1,912,890
St. Columcilles Hospital, Loughlinstown	6th Schedule	96,879	171,921	117,265	61,664
St. Michael's Hospital, Dun Laoghaire	5th Schedule	5,607,236	5,879,753	5,979,442	5,887,897
Cappagh National Orthopaedic Hospital	6th Schedule	1,920,838	1,921,199	1,506,230	1,939,682
Royal Victoria Eye & Ear Hospital, Dublin	5th Schedule	2,515,680	2,307,559	2,383,923	2,182,444
Total Ireland East Hospital Group		**99,299,626**	**109,022,207**	**109,833,152**	**99,982,038**
Cork University Hospital	5th Schedule	53,887,078	58,662,052	60,935,070	54,526,538
University Hospital Waterford	5th Schedule	19,329,732	23,851,598	23,530,764	19,127,349
Kerry General Hospital	6th Schedule	10,041,484	11,814,464	13,015,724	10,219,858
Mercy University Hospital, Cork	5th Schedule	18,917,636	18,315,003	18,317,841	18,389,962
South Tipperary General Hospital	6th Schedule	6,954,123	7,653,429	7,944,535	7,380,594
South Infirmary - Victoria Hospital	5th Schedule	9,146,737	11,440,007	13,763,719	11,529,518
Bantry General Hospital	6th Schedule	733,218	1,594,077	2,242,143	1,609,751
Mallow General Hospital	6th Schedule	2,504,304	3,196,832	3,183,787	3,518,133
Kilcreene Orthopaedic Hospital	5th Schedule	691,335	664,038	694,031	707,502
Total South Southwest Hospital Group		**122,205,647**	**137,191,501**	**143,627,614**	**127,009,205**
Galway University Hospitals	5th Schedule	37,562,958	36,507,379	39,268,158	38,852,466
Sligo General Hospital	5th Schedule	15,040,580	14,371,089	14,022,152	14,319,297
Letterkenny General Hospital	6th Schedule	7,077,776	6,588,115	7,720,236	7,239,411
Mayo General hospital	6th Schedule	7,580,085	8,274,061	8,719,363	7,793,993
Portiuncula Hospital General and Maternity	6th Schedule	7,137,963	6,498,735	5,709,290	4,931,517
Roscommon County Hospital	6th Schedule	2,636,075	2,247,258	2,143,983	2,588,344
Total Saolta Hospital Group		**77,035,437**	**74,486,637**	**77,583,181**	**75,725,027**
University Hospital, Limerick	5th Schedule	32,514,952	39,966,260	43,158,618	42,430,874
Ennis General Hospital	6th Schedule	1,833,563	2,328,604	1,882,574	2,723,838
Nenagh General Hospital	6th Schedule	2,315,405	2,700,753	2,701,250	2,334,160
St. John's Hospital, Limerick	6th Schedule	4,997,734	5,656,474	5,398,242	4,416,290
University Maternity Hospital, Limerick	5th Schedule	5,086,695	6,176,067	5,508,034	4,914,429
Croom Hospital	5th Schedule	3,796,372	4,082,068	3,624,349	3,659,830
Total UL Hospital Group		**50,544,720**	**60,910,225**	**62,273,067**	**60,479,421**
Our Lady's Hospital for Sick Children, Crumlin	5th Schedule	15,676,796	15,687,557	14,733,655	12,662,076
Temple Street, Children's University Hospital	5th Schedule	4,452,121	6,643,509	6,730,423	4,354,148
Tallaght Hospital Children	5th Schedule	3,609,121	3,628,978	3,028,978	3,034,527
Total National Children's Hospital Group		**23,738,038**	**25,960,044**	**24,493,056**	**20,050,751**
TOTAL ACUTE HOSPITAL DIVISION		**570,099,449**	**615,826,273**	**626,276,777**	**572,786,362**

* November YTD projected to year end


Summary Private Health Insurer Claims Process
Private Patient Discharged from Hospital
Consultant Documentation and Signature
Patient Accounts Department Collate Documentation
Patient Signature
Hospital Documentation and Invoice
Patient Accounts
Submits claim direct to Phi
Resolve Queries
Issue payment direct to HSE
Private Health Insurer (PHI)

Removal of Private Healthcare from public hospitals
HSE Submission to independent review

Background

Private Care has historically been a feature of the Irish public hospital service. Currently private income generates about €630m per year to fund public hospitals and represents about 12% of the revenue funding requirement. Private health care in public hospitals allows for the patient to choose their own consultant and the guarantee of consultant delivered, rather than consultant led care. Private patients also have the option to request a single occupancy room, subject to availability. Private care also allows consultants to supplement their income by treating and charging private patients. The private facilities in public hospitals are limited by legislation to inpatients and daycases only. Outpatients and the Emergency Department are public only facilities.

The latest data from December 2017 shows the public private mix at a system level stands at 82.2% public for in-patient work and over 85.8% for day-case work. National performance has been consistent at this level. The public/private mix for inpatient and day cases has remained consistent over the past few years 82% of all inpatient discharges are admitted through ED. The private/public mix is not uniform across public hospitals.

The Committee on the Future of Healthcare proposed "*the phased elimination of private care from public hospitals, leading to an expansion of the public system's ability to provide public care. Holders of private health insurance will still be able to purchase care from private healthcare providers*". The Committee has also recommended the removal of inpatient statutory charges for public hospital care (€25m) in year 1 and the removal of the ED charge (€17m) in year 8. This change is also likely to affect charges for MRI scans provided by certain public hospitals to private outpatients, this charge is payable under Section 4 of the Health Services (Out-Patient) Regulations, 1993 (SI No. 178/1993).

In order for this policy to be successfully implemented from a HSE perspective there is a need for the implementation phase to be cognisant of a number of key considerations, these include;

- The loss of income to the hospitals would have to be funded from the exchequer
- The transfer of private patients from public hospitals to private hospitals
- The public hospitals would need to maintain the ability to recruit and retain highly qualified consultants

Eligibility, access and equity

Under the current legislation Irish residents have full or partial eligibility for free public hospital services. Full eligibility includes those with medical cards and allows for a full exemption for all statutory charges. Partial eligibility allows for access to public hospitals subject to the payment of statutory charges (€80) per night to a maximum of €800 and Emergency Department charge (€100). Patients are prioritised for assessment and treatment on the basis of need and chronologically. The current legislation allows patients the ability to cross over between public and private care, for example, a patient can have a private outpatient consultation followed by a public inpatient admission followed by a private outpatient consultation. This cross over allows patients access public inpatient treatment earlier than if they have taken a public outpatient consultation.

Legislative and legal issues

The concept of public and private beds in public hospitals, along with the "80/20 rule", was established under the Health Amendment Act 1991. This provided for an average of 20% of beds in public hospitals to be designated as private only. This designation by the Department of Health varied from hospital to hospital depending on local conditions. The concept of designated private beds was effectively abolished by the Health Amendment Act 2013. All hospital beds are now chargeable as private accommodation. There are no limits to the amount of private income hospitals can generate; however, there are limits on the percentage of patients under the care of consultants.
The pre 2008 consultant contracts limited private practice in public hospitals to the proportion of designated private beds in the hospital. Since the introduction of the 2008 consultant contract there are enforceable limits on the amount of private work a consultant can complete in public hospitals. The 2008 contract also limited the number of consultants who treat inpatients and day cases in the public and private sectors.

Patients currently have the option under section 55 of the Health Act 1970 to avail of private services in public hospitals. The operation of section 55 is currently under review by the Department of Health and advice has been sought from the Attorney General. Section 55 currently also provides for the treatment and charging of patients who have no entitlement (Non EU visitors). This provision may need to be maintained, particularly in the case of emergency admissions.

Recruitment and retention of personnel

The Committee acknowledged that *"removing private care from public hospitals will be complex. Given the acknowledged need to increase capacity in the public system, it is important that any change should not have an adverse impact on the recruitment and retention of consultants and other health professionals in public hospitals*".

This change in private practice may have an impact on both the retention of current consultants and the recruitment of new consultants. There are a number of reasons why consultants would choose to work in the public health services. These reasons would include education and research opportunities; clinical recognition, variety of caseload, work/life balance and pay. Consultants operate in an internationally competitive market with transferable skills and knowledge. There is no evidence to suggest that the current salary rates, which give recognition of private income, are attractive. Of the 84 consultant posts processed by the Public Appointments Commission 2016, 51 competitions had 2 or less applicants and in 22 cases no appointments were made. Without incentives including a monetary incentive it may be more difficult to recruit and retain top quality consultants. This could have an impact on the quality of patient care. Improved recruitment and retention means better access which in turn means better health outcomes.

Existing consultants

The current consultant contract provides that, *the Consultant may engage in privately remunerated professional medical/dental practice as determined by his or her Contract Type* the proposed change would effectively vacate elements of both the 1991 and 2008 consultant contracts. It would effectively eliminate all private inpatient and day case work from the 1,789 (66%) of consultants who hold Type B contracts which allow for limited on-site inpatient/day case private practice and may reduce the income for the 748 (28%) hold Type B*, Type C, or pre 2008 contract which allow for onsite and offsite inpatient private practice. There may be a requirement to either compensate these consultants for loss of earnings and/or renegotiate contracts. Consultants currently on type B contracts may request type C contracts which allow them work in private hospitals. The total number of consultants holding category 2, type B* and type C contracts is subject to an upper limit of such posts. Appendix VII of the 2008 consultants contract ('Correspondence between the parties') suggests that this upper limit will be in the order of approximately 700 posts for type C.

Consultants are already opting to work full-time within the private sector. There is a very large and disproportionate growth within certain sectors or specialties in private healthcare which is related to the demands of an increasingly aged population. This is creating significant opportunities within specialities to achieve disproportionate financial rewards as compared to other medical specialties particularly in areas such as joint replacement or cataract surgery. General healthcare might be better served across sectors by addressing and balancing these differentials. This could include, not only specialties, but also the public/private and rural/urban divide as is the case in Scandinavian countries, without stifling initiative and inventiveness.

Training and Education

Recruitment and retention may also impact the development of the health care system as it could influence the calibre and quantum of research and education undertaken by consultants. The training and education of both medical students and non-consultant hospital doctors is a core element of the consultants' role. It is difficult to anticipate precisely if and how the development of the Irish health care system through research and education would be impacted by removal of private patients from public hospitals. This can be a factor for public hospitals if;

- Standards are of a lower quality and less well monitored and maintained
- Staff are difficult to recruit, less competent and poorly motivated
- Community and hospital care remains poorly balanced
- Educational opportunities continue to expand in private hospitals, especially the larger ones that are becoming increasingly aligned to medical schools

If consultants are to continue to work in both the public and private systems this would require,

- Parity within teams, contracts, admitting rights etc.
- Clear Job Plans
- Shared clinical data across the public/private systems
- Greater incentives within the public system to counteract the 'prestige' factor of working in the private system

New Consultants

In order to attract new consultants into the public system there would need to be a new or renegotiated contract which would allow consultants to receive remuneration comparable to the levels in the private sector. This contract may require differentiated pay scales to reflect the levels of work available in the private sector for different medical specialities. It must be noted that the absence of significant private hospitals outside the main population centres may inhibit consultants taking posts in locations where there is limited private healthcare facilities.

At the time of the 2008 contract negotiations the issue of private co-located hospitals was explored by HSE. The creation of co-located private hospitals under common governance was intended to facilitate the provision of additional capacity in the public hospital system, while maintaining the ability of the hospital to recruit and retain top quality consultants.

Current and future funding arrangements

When funding is viewed globally, the opportunity may exist to use a value based pricing system to fund care across care environments. Activity based funding under the governance of the Healthcare Pricing Office is in line with current policy and offers a single administrative way of paying for patient care. Activity based funding does offer a future arrangement for calculating and making payment for healthcare provision in both the public and private sectors.

With regards to the current funding system, the elimination of private healthcare from public hospitals will cost the health care system in the region of €630m per annum. The plan currently also envisages the elimination of statutory inpatient charges in year 1. Therefore the full replacement funding would be required. Any potential savings may be impacted by future requirements for administrative or payment mechanisms.

Operational matters including specialist services

The Committee on the future of Healthcare proposed *"the phased elimination of private care from public hospitals, leading to an expansion of the public system's ability to provide public care. Holders of private health insurance will still be able to purchase care from private healthcare providers".* This element of the plan would have an impact on both hospital services and patients.

There are considerable private healthcare resources in Ireland. This is not surprising considering that 42% (about 2.1 million) of the population are privately insured. Private hospitals have grown in Ireland in the last 30 years, however, most of the significant developments have been in the greater Dublin area. The 19 Private hospitals make a substantial contribution to Irish healthcare. Private hospitals now account for approx.

- 1,000,000 bed nights each year
- Care for over 400,000 patients annually
- Carry out over 250,000 surgical procedures including over half of all spinal and cardiac surgeries

They have the ability to invest in leading edge technology and expertise including robotics and PET/CT and make these available to public patients. Currently, all private hospitals are independently accredited. This is a requirement of the members of the Private Hospitals Association. Formal accreditation (by JCI), is the accepted international standard. There are a limited number of public hospitals who are accredited by JCI at the present time, these include St Vincent's University Hospital, the Royal Victoria Eye and Ear Hospital and the Rotunda Hospital.

There are a significant number of co dependencies between the public and private health sectors. These include access to private hospitals for public patients, and healthcare education and access to public hospitals in emergencies for patients from private facilities. Consultants and their patients can access private hospital facilities, theatres for elective surgery, new technologies and allows consultants to maintain their skills in specific specialist areas. The public hospital system provides training for all healthcare professionals, including those employed in the private healthcare system. While the larger private hospitals are now largely self-sufficient with sophisticated ICUs, the practice of transferring a patient whose condition significantly deteriorates to public hospitals continues. All of these co dependencies may be impacted by the proposed change in practice.

Impact on hospital services

All private patients have limited or partial eligibility to free public hospital services. For a number of reasons these patients may choose to remain or may have to remain in the public system. Alternatively private hospitals may not be in a position to admit these patients. In the event that all private practice was transferred from public hospitals to private hospitals, then the private system could be overwhelmed by the transfer of patients. The private system, as it stands, does not have the capacity to manage all private patients managed by the public system. There are a number of specialities where there are no private hospitals, these include paediatrics and obstetrics. There is a particular issue with indemnity for consultant's insurance requirements for private obstetrics. In order to facilitate private practice for obstetrics where there is no private practice in public hospitals, the terms of the Clinical Indemnity System may need to be examined.

Reasons patients would remain in the public system would include;

- Lack of capacity within the private system
- Lack of an alternative location for their specific treatment in the private system
- Lack of enhanced chronic disease management in the private sector
- The absence of admitting rights into a private hospital for the consultant

- The patient may not have sufficient insurance cover for the private hospital.
- Limited private hospital ED and other emergency services including 24/7 access to theatre
- Restricted access to Allied Health and Social Care professionals
- Some Private hospital may be unable to deal with significant patient comorbidities

There may also be a requirement to restrict treatment to a designated National centre or centre of excellence, for example cancer surgery, transplant etc.

These reasons and in particular the lack of 24/7 emergency services, the absence of significant private hospital facilities outside the main population centres and the lack of private facilities for chronic disease management may restrict the number of patents who can transfer to the private sector.

Impact on patients

Communication of this change will need to be communicated carefully to the general public. The current government policy is to provide access to universal health care. The segregation of patients who have opted for private treatment for a particular episode of care may have an impact on their further clinical treatments. For example, this process may have an impact on significant minority diseases and specialist patient clusters that access their care through public hospitals only. It may also impact patients who have access to free healthcare under specific legislation such as the Hep C patients. It is also the case that access for a patient to public social care, as well as access to the cross border directive and treatment abroad scheme is dependent upon the patient's eligibility status. The selection of a public or private facility for an episode of care may limit further patient options. These different scenarios may need to be investigated before an implementation plan is finalised

The price of private healthcare in the public system differs from the price in the private system. The public charges are based on a per diem rate as outlined in legislation; the cost in the private hospitals is set by the hospital and the reimbursement is a negotiated rate between the insurer and the relevant hospital. Currently, there are in excess of 350 private health insurance policies in existence, these cover public hospitals as well as selected private hospitals and in some cases selected procedures. While generally the full acute stay in the public hospital is covered by insurance, in the private hospital the patient may experience additional out of pocket expenses or co- payments. If patients are unable to access private hospitals for their treatment either due to medical or economic reasons they may choose to cease holding private insurance policies. Currently 84% of private activity is generated via the public Emergency Departments. If this is maintained insurance may only become relevant for elective admissions treated in the private sector. This could result in a fall in premiums.

Licencing

Legislative proposals are at an advanced stage of development for the introduction of a national licensing system by 2020. This will provide for a mandatory system of licensing for public and private health service providers. It will be designed to improve patient safety by ensuring that healthcare providers do not operate below core standards which are applied in a consistent and systematic way. Licencing may result in certain procedures or treatments being available in the public or private sector only. In that scenario an insured patient may not be in a position to transfer to a private healthcare setting. There may also be a cohort of private patient that may have to transfer to public hospitals based on their clinical needs to conclude their treatments. Both of these cohorts of patients would have to be managed in a way that respects their clinical requirement while acknowledging their public/private status.

Practical approaches to removing private practise from public hospitals including timeframe and phasing

Legislative changes to section 55 of the Health Act will be required to in order to facilitate the removal of private practise from public hospitals. This may need to be accompanied by similar changes to the primary care eligibility legislation so that there can be a seamless transfer of public patients between hospitals and primary and social care services. There may also need to be contractual changes for consultants to address the private income elements of their contracts. This will need to be followed by internal information and external communications so that hospitals, hospital staff and patients are fully aware of the impact of these changes. In order to maintain consistency the implementation of the change should be universally applied from a single date.

Conclusion / Comments

There are a number of suggested issues for further investigation before a plan for the implementation of this policy is finalised. These would include;

- The ability of patients to transfer to the private sector based on the current insurance market, the current geographic spread of private healthcare facilities and their ability to provide 24/7 access
- The opportunities to enter into a partnership with private hospitals to address elective demand including waiting lists
- The impact of these changes on patients ability to access public health and social care including cross border, treatment abroad and free care provided under specific legislation
- The potential impact of the changes on consultant retention and recruitment and an examination of changes that may be required to the consultant contract in order to maintain the quality of consultants within the public system

Slaintecare provides an opportunity for a greater emphasis on the functional and physical separation of acute and planned or elective care in separate buildings/hospitals. The majority of the acute (+chronic disease and national services) sector may of necessity need to be provided for within the public service.
Planned patient services may be able to be divided between public and private institutions, and the private sector may be able to provide an overflow service to the public system by franchise.