National Clinical & Integrated Care Programmes
Person-centred, co-ordinated care

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Clinical Strategy and Programmes Division

Clinical Strategy and Programmes Division

Topic: Independent Review of Private Practice in Public Hospitals

The review group would like to receive written submissions from interested parties on the current arrangements in relation to private practice in public acute hospitals; on the future direction that might apply; and on suggestions in relation to transitional arrangements to give effect to the future direction. In particular, the group invites submissions related to the following six themes:

1. Eligibility, access and equity
2. Legislative and legal issues
3. Recruitment and retention of personnel
4. Current and future funding arrangements
5. Operational matters including specialist services
6. Practical approaches to removing private practice from public hospitals including timeframe and phasing

**Submissions should be made by e-mail to IRGPrivatePublic@health.gov.ie by 9th January 2018 (email request received 28 December 2017)

Theme 1: Eligibility, access and equity	• In line with the Oireachtas Committee Report on the Future of Health Care Sláinte, all public patients should have equal access to public health care therefore, if patients choose to use their private insurance, they should only be treated in private health care settings. However it could be argued that this reduces patient choice. • Will private facilities have the capacity to serve a significant percentage of the population should private practice move out of public services? How could this impact on access and eligibility into either service? • Emphasis on private practice and/or inadequate public health services may further impact the already widening economical divide within the population. A balance needs to be struck if both are to co-exist.

	• Other jurisdictions allow a capped income for private patients that supplement patient care and research to develop life-saving treatments.
Theme 2: Legislative and legal issues	• New legislation to ensure that private practice is not permitted in public hospitals, legislation only to be enacted when required infrastructure is in place. • Robust public and staff engagement on the Heads of Bill due to the necessity for patient data exchanges between both sectors. • Legislate for penalties and a regulator/monitoring agency as part of the legislation via independent trust status of hospitals legislation or licensing. • There will be a need to change consultant contract to reflect this legislation - a move that will have legal implications.
Theme 3: Recruitment and retention of personnel	• Draw up national guidelines on recruitment and retention of personnel to support all services in the development of their own specific marketing documents/strategy. The National guidelines should include: ○ benefits of working in the organisation/service in a clear and inviting manner ○ considerations on how to meet the expectations of the different generations e.g. Generation X and Y ○ guidance on developing inviting packages to disseminate to attract different professionals/personnel ○ emphasis on the quality and education/development aspects of working in the organisation ○ information on good clinical governance and a culture of learning and empowerment ○ information on accommodation, relocation packages, etc. ○ Leads' Contact details

	• Need to guard against incentivised recruitment to private sectors at the expense of the public sector (as we could end up with a system like the US which is very unequal). • Similar condition of service and equity in remuneration per grade should be ensured for ALL staff working in both health sectors to include HSCP, Nurses, HCA, etc.

Theme 4: Current and future funding arrangements	• Robust objective examination of the existing level and role of private practice in public hospitals is required, as well as associated costings.
	• Projections for impact on hospital activity funding if same removed.
	• Demographic projections need to be taken into account.
	• An increase in public funding will be required to account for the reduction in private funding mechanisms if separated out and legislation will be required around new funding arrangements.
	• Renegotiation of consultant contracts will be needed to maintain a competitive package and ensure public facilities remain attractive.
	• Transitional funding needs to be realistic to ensure that the need for a sufficient increase in capacity is met with adequate funding, following the bed capacity review.
	• Community healthcare costs will undergo dramatic changes to current funding models – difficulties exist in predicting the impact of this parallel process which will also have implications for cost and demands on public funding.
	• Removing private practice from public services will be expensive. Hence several questions need to be considered:
	  ○ Is there a political will to raise taxes or insurance premiums sufficiently to meet this cost?
	  ○ Are we ready to change fundamentally our socio-economic structure to become more like the Scandinavians and pay significantly more taxes for public services?

	This debate needs to happen or we may follow the UK NHS current path of privatisation.
Theme 5: Operational matters including specialist services	• Either during the decoupling of public/private practices or the discontinuation of one or the other, there will be a need for robust governance to ensure strict adherence to what is permitted within existing contracts. There is also a need for transparency, monitoring and publication of findings and progress reports made available by both sectors. • Impact on staffing and services must be considered: if senior consultants and other experts and technicians can no longer practice in both public and private hospital how will this impact on services? • The implications of removing private practice from public healthcare and impact on attracting and retaining experienced medical staff and other experts will have to be explored. • Private health providers are unproven in non-selective provision of health care to date; the claim that they could manage the public service more efficiently is as yet unsubstantiated as they are selective with regard to the treatments and services they offer – e.g. Emergency Department services as one example. Will this continue to be the case or will all hospitals either be specialised or be general? • Consideration will be required of the current and future impact of situations where patients treated in private facilities return to public healthcare for after care and/or where patients are transferred/referred to public facilities with complications after treatment/care in private facilities. • The maternity service operates quite differently than the general Hospital Services. There are no private maternity hospitals since the closure of Mount Carmel therefore Consultants are reliant on the public service to support their private practice. An understanding is needed on how this currently operates and its implication on funding from such private practice to the hospitals for public services.

Theme 6: Practical approaches to removing private practise from public hospitals including timeframe and phasing	• Gradual phasing out of private patients being eligible to access public beds over a timeframe that will support private hospitals to plan for the future care of all private patients. • Review of Hospital Consultant contracts, so that in the future consultants may work only in public OR private practice. • For existing Hospital Consultants, putting systems in place from an accountability perspective, to ensure that their contracted allocation of time spent in public and private practice is adhered to. • Private hospitals should no longer be used for government funded care of public patients. This will incentivise them to focus on providing their service exclusively to their private patients. • Ensure senior medical staff are consistently present in Emergency Departments to make decisions in relation to the admission and/or discharge of patients so that target waiting times are upheld. • When private patients attend Emergency Departments in Public Hospitals and/or are admitted, they should be transferred to a private hospital that will meet their needs, as soon as they are sufficiently physically fit. • Review of hospital systems in terms of staff, processes and resources to ensure diagnostics, care and management of in patients occur are timely and efficient. • Leadership development for all managers in both the acute and community services to ensure they work together to achieve seamless, timely, efficient integration of services. • Practical approaches to removing private practice from public hospitals including timeframe and phasing. The establishment of separate private hospitals will require more building capital and an increase in number of trainees to meet future demand. This however brings with it capacity issues for practice.