Consultation on Private Practice in Public Hospitals

Submission from Róisín Shortall TD

At the outset I wish to point out that the Committee on the Future of Healthcare was very specific in respect of the remit of the expert group. Sláintecare states “the Committee recommends an independent impact analysis of the separation of private practice from the public system with a view to identifying any adverse and unintended consequences that may arise for the public system in the separation.” While separating public and private care in public hospitals will have various impacts on different aspects of general healthcare provision and what can be termed the healthcare commercial market, the committee specified that it is the impact on “the public system” which must be assessed and not the potential impact on commercial interests. I believe that this is a critical point which reflects the determination of the committee that the objective of the reform programme is a fully functioning public healthcare system.

The basis of this submission is the agreed findings on private practice in public hospitals included in the report of the all-party Committee on the Future of Healthcare. The Sláintecare report sets out an agreed cross-party plan for the provision of a single-tier, universal national health service in Ireland over the next ten years. A key recommendation of this report is that private care must be removed from public hospitals between year two and six of the implementation. While the report acknowledges that this will be a complex process, it should be noted that it is a core tenet of the Sláintecare plan. It is also worth noting that Ireland is extremely unusual in a European context in terms of the difficulties in accessing care for many people, the full price and high cost paid by many people, and the absence of legal entitlements to care. Ireland is also unusual in that those with supplementary private health insurance or who can pay out of pocket are able to access hospital services quicker than those in the public system who do not have private health insurance. There is an obvious need for greater accountability in our health system, and particularly in our state-funded hospitals. The state spends billions of euro each year funding these essential services, we have a right to know how our money is being spent. The only way that this can be achieved is to disentangle our public health system from private medicine.

As it stands, Ireland is spending €20 Billion on health, Currently, the Irish healthcare system is funded primarily through general taxation (69%), private health insurance (12.7%) and out of pocket payments (15.4%). When we consider the fact that 47% of the overall population is covered by health insurance policies, we can assume that cross-subsidisation is prevalent. Private health insurance (PHI) occupies a unique role in the Irish setting providing faster access to care in both public and private

provider settings. Nevertheless, the benefits only accrue to those who are able to afford to pay the premium for health insurance. Nevertheless, the existence of PHI, while related to faster access, reinforces a two-tier health system, particularly for elective acute care, which runs counter to the aspirations for a single-tier health system. As a result of this complex funding mix, there is a near total absence of transparency regarding the level of cross-subsidisation from public funds to doctors and senior managers in publicly-funded hospitals, to the health insurance firms that place their clients in those hospitals, and to the supposedly separate private clinics which many voluntary hospitals operate alongside their state-sponsored operations. It is impossible to establish whether we are getting value for money from our public hospital beds, for example, or from our publicly funded equipment, our consultants or other healthcare staff. Without a clear line of sight of resources, transparent data and effective information systems, it is not possible to establish accountability at either administrative or clinical level.

Up to 2014 there was a 20% limit on the amount of private work which could be carried out in public hospitals. This reflected the majority of consultant contracts which allowed them to engage in a maximum of 20% private work. This limit was lifted in 2014 and hospitals were given targets for private patient income. These targets have since been increased, year on year. This represents a classic perverse incentive and operates against the principle of equity of access. Public hospitals treat more private patients at the expense of the public patients they were set up to care for, while at the same time boosting the incomes of consultants already generously rewarded by the taxpayer. The Committee on the Future of Healthcare strongly recommended that these perverse incentives should be removed by phasing out private work from public hospitals between year 2 and 6 of the Sláintecare plan and replacing private patient income currently received by public hospitals over the same period. Based on current figures, this is costed at €649m (See Appendix 1). The Committee recommended that this income stream be replaced by additional public funding over a five year period, starting in year 2. Over this time, this income will be replaced by activity based funding for public patients, as more public patients will be treated and private patient numbers decrease. This will allow the private sector to operate more independently, and public resources to be channelled to public patients. The continued delivery of private care in public hospitals works against the delivery of a single tier universal system and hence the realisation of the Committee's Terms of Reference. As noted in the key principles agreed by the Committee: "Public money is only spent in the public interest/for the public good, ensuring value for money, integration, oversight, accountability and correct incentives."

In practice, this means that private beds will no longer be provided in public hospitals. Instead, the capacity of public hospitals will be built up over time while private care is removed from public hospitals.

This will require:

- A fund to replace the €649m (2016 figure) private patient income in public hospitals between year two and six of the plan

- Consultants will only treat public patients in public hospitals, the proportion of private work in public hospitals will be eliminated over a phased period

- The recognition of the need for enhanced public only consultant contracts for new entrants.

- Careful workforce planning to meet current and future staffing needs, and measures to ensure that public hospitals are/become an attractive place to work for experienced, high quality staff

- Robust workforce planning which ensures that we maximise the utilisation of the skills of every worker that are currently available within the health service

- Sufficient numbers of consultants and other essential healthcare professionals to meet population need

- Current unacceptable waiting times for public hospital care in emergency departments, outpatient clinics (OPD) and planned daycase and inpatient treatment must be reduced so that timely access is provided, based on need and not ability to pay

- The successful re-orientation of care delivery to primary and social care settings so that most care is provided (publicly) outside of hospital

Beyond the issue of the lack of transparency, is one of basic fairness, where treatment in public hospitals is on the basis of need and not ability to pay. Our hybrid system, which is unique in the western world, permits doctors to use publicly-funded hospitals, facilities, ancillary staff and diagnostics to treat their private patients. It should be noted that the significant savings arising from the ending of this cross subsidisation would go a considerable way towards offsetting the loss of private patient income of €649 million referred to earlier. The opaque blending of public interest and private gain creates a classic perverse incentive and contributes to the continued growth of waiting lists. Paying publicly-funded hospitals and consultants to treat private patients ahead of those in the public system whose needs may well be greater is simply indefensible and must cease. Currently in Ireland, private health insurance confers an advantage in terms of faster access to care. “An Irish College of General Practitioners survey of GPs commissioned by the Irish Cancer Society, highlighted the public private divide in stark terms. 88.5% of GPs surveyed said a patient’s ability to pay affected their ability to access diagnostic tests used to detect cancer.” (Irish Cancer Society). This mix of private incentive and public interest creates an ungovernable and unaccountable twilight zone, where State-paid senior

doctors are richly rewarded for pushing their private patients to the head of the queue for treatment. Inevitably, public patients pay the price for this and must wait even longer to access consultant care.

Successive reports have highlighted the lack of accountability of hospital consultants, who operate with an extraordinary degree of autonomy, and a lack of external oversight enjoyed by no other group of Irish professionals. This absence of accountability was to have been addressed in 2008 when the new consultants contract was negotiated. This was supposed to control consultants' private practice by limiting the amount of private work most consultants could do. For the vast majority of consultants, this ratio was set at 80 per cent public work and 20 per cent private. Currently, just over 2700 consultants work in 47 acute public hospitals across the country. The 2008 contract provided significant pay increases to consultants in return for agreeing to limit their private practice. Under the deal most consultants are contracted to work 39 hours per week in the public system (other consultants who remained on the old contract stayed on 37 hours). Today, consultant salaries range from €113,000 to €229,000 before on-call & other allowances are added in.

HSE figures nationally show the agreed 80/20 ratio is being met, however these figures mask the fact that the ratio target is only being met because some hospitals preform exceptionally well in treating public patients and carry out very little private work. However, a sizeable number of regional hospitals are significantly off target and this is having an impact on public patients. This is outlined in Appendix 2.

Data obtained by RTÉ Investigates in December 2017 found that while some hospitals were compliant with the public private mix, individual departments within these hospitals exceeded the 20% private ratio. This meant in 2015, the number of private patients treated in these public hospitals in excess of the 20% ratio was over 19,500. In 2016 the excess number increased to almost 24,000.

That programme found that while a number of consultants exceeded their 20% contract terms, in addition to this, a sizable minority were working offsite and failing to fulfil their contracted hours. Previously the HSE routinely published data on compliance with private practice limits, however the HSE no longer keeps national figures and in 2014 it stopped gathering the information outright. The new contract was supposed to make consultants accountable to a new tier of clinical directors, appointed from within their own ranks, and paid an extra €46,000 a year. A form of flimsy self-regulation, in which those appointed as clinical directors were supposed to "police" the working hours of their peers and even friends. There is little evidence that this worked.

By November 2009, a year after the new contract was implemented, senior health service officials told the Public Accounts Committee that hundreds of hospital consultants around the country were flouting the conditions of the contract by treating too many private patients. In 2015, the head of the Health Service Executive

told the Minister for Health the application of the 80/20 split to senior doctors had, in practice become a “farce”. The head of the HSE also described St. Vincent’s Private Hospital as having a ‘parasitic relationship’ with the public hospital to the PAC in 2015. He estimated that 56% of consultants admitting patients to St Vincent’s Private Hospital did not have contractual rights to do so.

Currently the majority (81%) of consultants have contracts which enable them to work privately in public hospitals. The development of elective only hospitals in each Hospital Group, as recommend in the Sláintecare report, could act as an important counterbalance for consultants to private sector work, by creating new opportunities for the development of their specialist skills through elective work in the public sector. The new consultant contract was meant to also entail a single waiting list for public and private patients. This never materialised in any kind of meaningful way, again removing an important element of accountability. This principle should be reinstated and rigorously operated in practice during the interim phase. In addition, these lists should be publically available on the grounds of transparency and also to give choice to patients to opt for the shortest list if they wish to do so.

The task in hand for the expert group is indeed a complex one and reflects the complex and unique nature of Ireland’s two-tier health service. It is this very complexity, inherent in the two tier system, which militates against equitable access, efficiency, value for money and transparency within our health service. The Committee on the Future of Healthcare, having studied all of the evidence presented to us, came to the undeniable conclusion that fundamental reform and the achievement of a universal single-tier system would be not be possible as long as the cross subsidisation of private care in our public hospitals is permitted and incentivised.

As chairperson of that committee I would strongly urge your group to reflect the clear and unambiguous desire to “establish a universal, single-tier service where patients are treated on the basis of their health need rather than their ability to pay” as unanimously agreed by Dáil Éireann on 1st June 2016.

With every good wish in your important work.