Irish Life
health

Consultation on Private Practice in Public Hospitals

Background

Irish Life Health welcomes the Slaintecare Report and the ambitious recommendations set out therein. In particular, Irish Life Health endorses the recommendations relating to increasing prevention, the expansion of primary and social care models and in particular the shifting of medical care away from the acute hospital sector and into the community.
Irish Life Health as a health insurance undertaking will however limit its views to those pertinent to health policy which may impact health insurance customers rather than expressing a view on wider policy issues.

Private health insurance has formed an intrinsic part of the Irish health care system since 1957. The largest provider of private hospital services in the State is the HSE, which now receives an annual payment in excess of €600 million from private health insurers. In addition to this, private health insurance companies also pay an estimated €140m to medical Consultants working for the HSE. Policymakers and those responsible for the management of the public health system have a duty of care and responsibility to ensure that health insurance customers receive value for this spend.

Executive Summary

Irish Life Health believes that:

- The private and public hospital system should work collaboratively to deliver the best outcomes and services to all who require access to health services. An important component of this is to optimise the use of all bed and medical capacity within the State.
- There should be parity of charging between private and public patients where services received are the same.
- In the interests of fairness and transparency for all involved the remuneration structure for Consultants and other practitioners engaging in private practice in public hospitals should be clearly defined.
- Private patients should be re-directed to private facilities where these are available to alleviate congestion within public hospitals.

What is required is a solution that utilises all resources within the State (both public and private), working together to best allocate and distribute healthcare. With current occupancy rates within acute care in public hospitals at approximately 95%[1] throughout the year better utilisation of all bed capacity needs to be implemented. Incentives should be introduced so that those who can and wish to purchase health insurance do so and source their care through private facilities, therefore freeing public hospitals to treat more public patients.

Irish Life Health believes that further examination should be given to the Australian healthcare model and in particular the distribution of hospital and medical resources in Australia – for further information please see Appendix 1.

[1] OECD/European Observatory on Health Systems and Policies (2017), Ireland: Country Health Profile 2017, State of Health in the EU.

Eligibility, access and equity

Eligibility: Universal entitlement to access public health facilities for all citizens should remain, regardless of whether a person has or has not private health insurance and no person should be turned away due to their insurance status (or otherwise).
Irish Life Health believes all patients who access a public hospital through accident and emergency should be regarded as public patients and be treated equally from a medical, access and charging perspective.

Access: For elective treatments; private patients should be incentivised to firstly access treatments through private hospitals where these are available.
All citizens have a universal entitlement to access public hospitals and this principle should remain – however where there is opportunity to receive treatment within the private hospital system this should be encouraged.
While an ambition outlined within SlainteCare is the removal of private patients from public hospitals to allow for the expansion of capacity in public hospitals it is questionable whether this policy will have the intended effect. 82.4%[2] of in-patient discharges within the HSE hospitals were from emergency admissions and 17. 6% were due to elective discharges but it is unknown what percentage of these elective discharges were related to private in-patient procedures.

Private day case procedures within the HSE, up to September 2017 accounted for 14.2% of private treatment and this percentage has been falling year on year. However, while elective private work has decreased, the public waiting list has not in turn dropped. Hence other structural supports are required to improve the public hospital system. Taking measures to alleviating demand on the public system will provide one part of the solution.
As stated above Irish Life Health believes that all the resources within the State should be used and as such private patients were appropriate should be re-directed for elective treatments into private hospitals. Where certain elective procedures are only available within a public hospital then once additional services are provided by the hospital and Consultant then private patients should be charged accordingly.

Current and future funding arrangements

Private health insurance provides approximately €600 million in funding to public hospitals and €140 million in medical fees to Consultants working in public hospitals. This income would need to be replaced within the hospital if any changes occurred.
The removal of all private patients would therefore necessitate an increase in funding of public hospitals and also a review of current Consultants contracts and salary ranges. Some of these costs could be offset by allowing Consultants also practice within private hospitals.

[2] HSE Performance Report – Management Data Report September 2017

Legislative and legal issues

The evolution of legislation within the health insurance market has led:

- to private health insurers being forced to drive consumers into public hospitals;
- to the public bed charges creating a situation where public hospitals have a financial incentive to prioritise private patients over public patients.

This has created inequity for public patients, but also for private patients who are paying twice to receive the same service (private patients are charged €813 per night for the same public bed, or in some instances even trollies, and normally receive attendance by the same Consultant they would see as a public patient) which have already been paid for through taxation.

Minimum Benefit Regulations

The Minimum Benefit Regulations[3] specify that all health insurance contracts must cover as a minimum the daily charge in a public hospital without any negotiation or dialogue on rates, lengths of stay or service standards. This forces health insurance companies into having to unilaterally cover treatments within public hospitals. Parity of negotiation

Risk Equalisation Levy

The government introduced a risk equalisation scheme through the implementation of a flat rate health insurance levy and age related tax credits in 2009. This levy scheme was subsequently amended in 2012 and the concept of "non-advanced" plans was introduced in order to alleviate the impact of a flat levy on plans with lower cover.

The legislation sets out on what basis a plan may be deemed an advanced or non-advanced plan. If a health insurance contract has more than 65% coverage for any private hospital it is automatically deemed an advanced plan. The legislation therefore favours the provision of public hospital coverage over private hospital coverage in order to avail of a lower levy and pushes patients into already overcrowded hospitals. This is an artificial construction as in a number of cases public hospital charges are more expensive than private hospital charges, in particular when looking at side room procedures. For example, this change in legislation stated that no more than 65% of the cost of a day case treatment could be covered if it was carried out in a private hospital to avail of the lower levy. Therefore, to have full coverage of day case treatments all persons on non-advanced plans must attend public hospitals – currently 192,000[4] members on non-advanced plan whose only option to access public hospitals.

From 1 April 2018 the non-advanced levy will be €177 per adult and the advanced will be €444 per adult, hence the levy difference is large enough to make an impact on the relevant premiums.

Irish Life Health would call for a change to the current levy model based on a percentage of premium, this would remove the need for the current artificial differentiation between

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[3] SI 83/1996 Health Insurance Act, 1994 (Minimum Benefit) Regulations as amended

[4] Report to the Minister for Health on an Evaluation and Analysis of Returns for 1 July 2016 to 30 June 2017 including advice on Risk Equalisation Credits by the Health Insurance Authority

benefits on plans and would also be more equitable with those paying for luxury plans paying more rather than being cross-subsidies by those on lower plans.

Public Bed Legislation

The 2014 change to the designation of beds has created a scenario where the State can charge the same person twice for the same service and is making private patients more valuable to public hospitals than public patients; as evidenced by some public hospitals setting annual private income targets to be achieved from private patients[5]. Furthermore, where previously Consultants could only place private patients into designated beds (which was restricted to 20%) the change in legislation allowed Consultants to place private patients across the hospital.

Changes in legislation that would support a phased move of private patients away from public hospitals would be:

1. Deem all patients entering public hospitals through A&E to be public patients and charge these accordingly;
2. Make the risk equalisation levy a percentage of premium to allow coverage of private hospitals within all plans;
3. Change Minimum Benefit Regulations to stop coverage of public hospitals in certain instances.
4. Increase tax relief at source to help transfer more patients to private facilities.

[5] Dail Debate 1 December 2016 – response by Minister Harris to priority question from Deputy Louise O'Reilly.

Operational matters including specialist services

Irish Life Health does not have a view on operational matters or on specialist services other than to note that the additional services should only be charged where additional work different to that afforded via taxation is provided. Where identical services are provided by a hospital or Consultant to both private and public patients then identical charging should be implemented.
Transparency of what services are provided by either the hospital or Consultant should be paramount in any new system. Transparency will favour hospitals, Consultants and patients who should have better information and clarity around the provision of service.

Recruitment and retention of personnel

Consultants are earning approximately €140 million from private practice in public hospitals. Consultants should be facilitated in carrying out elective private practice within private hospitals once their public commitments have been achieved.
In addition, patients should have the freedom to choose to be seen in private out patient clinics that do not impact on public clinics. This would allow Consultants to continue to generate some additional income once they had fulfilled the public commitments.

Practical approaches to removing private practice from public hospitals including time frame and phasing

Irish Life Health believes that the practice of charging private patients who enter public hospitals through accident and emergency departments should be a first step towards the removal of private practice from public hospitals. All persons entering an accident and emergency department should be treated and charged in the same manner.

Where elective treatments are provided privately, this should be allied with a private room or semi-private room to justify the additional costs charged. Private Consultants should only be allowed operate private elective treatments once their public commitments have been fulfilled. Better supervision of the hours of work engaged in by Consultants both within public hospitals and in private hospitals should reduce disputes between hospitals, Consultants and patients.

The levy model within the health insurance market should be changed to a percentage of premium to allow members on lower based plans access private facilities rather than be driven into public hospitals.

Conclusion

The recent bed capacity review[6] has identified that at least an additional 2,500 beds are required by 2031. Private healthcare and private health insurance which covers 45%[7] of the Irish population should work in conjunction with the public system to achieve a solution that benefits everybody within the State. It is in the interest of State to keep and maintain both a vibrant health insurance and private health provider market. Any erosion of either the health insurance market or collapse of a private hospital would have a severely detrimental impact on the public healthcare system.

Irish Life Health would welcome the opportunity to meet with the Independent Review Group to further discuss this submission.

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[6] Health Service Capacity Review 2018 - http://health.gov.ie/blog/press-release/capacity-review-shows-investment-and-reform-must-go-hand-in-hand-if-we-are-to-break-the-cycle-of-hospital-overcrowding-minister-harris/

[7] HIA Newsletter November 2017

APPENDIX 1 – AUSTRALIAN SYSTEM

The public policy approach adopted by Australia has taken a fundamentally different approach with the principle that the private and public systems need to support each other and those that can afford private health insurance should take this out and receive treatment within private hospital facilities. The Australian Government supports access to private health insurance by providing means tested tax rebates (which are reviewed annually) and a tax surcharge for persons over a certain income who fail to take out health insurance.

There are little to no waiting times to access public facilities in Australia as care is split between the public and private systems.

In Australia (in 2013-2014) there were 1,359 hospitals[8] of which 747 were public hospitals and 612 were private. At June 2015, 47%[9] of the Australian population had some form of private hospital cover. Hence Australian public policy is premised on maintaining and sustaining a properly functioning public and private hospital system and properly utilising all hospital capacity regardless of its nature.

Medicare principles stipulate that private patients in public hospitals do not receive preferential access to services in a public hospital setting and that the only driver for prioritising treatment is the nature of a person's clinical condition. Patients who choose to declare their private status within a public hospital however are afforded a choice of doctor within the public hospital.

The issue of private patients within public hospitals in Australia has also been examined through a similar lens to Ireland on the impact this is having on public waiting lists. One study[10] did find that abolishing preferential access for private patients and public patients would only lead to a small improvement in waiting times for public patients because the long public lists are primary due to budget constraints in public hospitals rather than queue skipping.

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[8] Australian Institute of Health and Welfare – Australia's health 2016 - https://www.aihw.gov.au/getmedia/9844cefb-7745-4dd8-9ee2-f4d1c3d6a727/19787-AH16.pdf.aspx?inline=true

[9] Ibid 8 above.

[10] Johar, M. and Savage, E. (2010), Do Private Patients have Shorter Waiting Times for Elective Surgery? Evidence from New South Wales Public Hospitals*. Economic Papers: A journal of applied economics and policy, 29: 128–142. doi:10.1111/j.1759-3441.2010.00058.x

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