Submission on Private Practice in Public Hospitals

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Submission by:

THE IRISH HOSPITAL CONSULTANTS ASSOCIATION

HERITAGE HOUSE, DUNDRUM OFFICE PARK, DUNDRUM, DUBLIN 14

TEL: (01) 298 9123
E-MAIL: info@ihca.ie
WEB: www.ihca.ie

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Executive Summary

If implemented, the proposal to remove private practice from public hospitals will have far reaching adverse consequences for the delivery of acute hospital services in Ireland. It will have a devastating effect on the financial viability of the acute hospitals, reducing their capacity to treat an ever increasing number of patients. The proposal will exacerbate the current Consultant recruitment and retention crisis and cause an exodus of existing Consultants thereby reducing the availability of highly specialised clinical services to patients in public hospitals.

The difficulties and challenges faced by the public acute hospital system are not caused by public or private patients in public hospitals. They are a consequence of years of underfunding and under-resourcing, which have severely restricted and reduced the capacity of public hospitals to meet growing demand.

Privately insured patients in public acute hospitals represent just 18% of all inpatient discharges and just 14% of day case admissions. The percentage of patients in public hospitals treated privately is disproportionately low bearing in mind that 45% of the general population has private health insurance cover.

There is a misconception that Ireland is an outlier among other countries by virtue of the public/private mix within its public hospital system. There are many examples of public health systems that facilitate private practice in public hospitals in other EU countries, Australia and other jurisdictions. There is international recognition of the benefits and advantages associated with facilitating this practice.

The Department of Health's White Paper on Private Health Insurance in 1999 identified significant advantages and benefits of the public and private mix in delivering hospital services, including a need to fund the public hospitals. This remains valid today as it is not realistic for the public hospital system to be exclusively dependent on the Exchequer for the entirety of its funding.

Permitting consultants in public hospitals to treat private patients is a key contractual provision that is essential to attract and retain specialists in an internationally competitive marketplace.

Funding

The proposal will have the effect of removing €6.5bn in private health insurance income in static terms over a 10 year period. Adjusted for inflation, the estimated loss will be closer to €8bn or €800m per year.

The proposal will result in larger acute hospital budget deficits with inevitable consequences for patient care. Moreover the overall cost of implementing all 23 proposals in the Slaintecare Report is grossly underestimated at €2.8bn which is Year 10 costs, in contrast with €19.8bn to phase them in over the initial 10 years, with the cost increasing to €28bn plus inflation in subsequent decades.

Based on experience in recent decades and all the challenges impacting on the national finances, the IHCA and its hospital consultant members have no confidence that the loss in private health insurance income will be replaced by the Exchequer. The State has for decades struggled to adequately fund the public acute hospital system. Also in the context of the existing hospital capacity deficits and the ESRI projected 37% increase in demand for hospital care by 2030, removing the private revenue stream will cripple the public hospital system.

Eligibility, Access and Equity

The proposal will reduce hospital access and result in deteriorating services for all patients who depend on public hospitals. The proposal will also reduce access to specialised clinical services for patients in public hospitals because it will create an unprecedented Consultant recruitment and retention crisis. Access to emergency and elective care will deteriorate because an increased number of both public and privately insured patients will present at public hospitals, driven by demographic factors, while the finances of the public hospitals are further constrained by removing private funding.

The proposal will result in an extreme two-tier system with functioning and adequately resourced private hospitals operating in parallel with under-resourced and overcrowded public hospitals.

Legislative and Legal issues

The proposal will create significant difficulties from legal and industrials relations perspectives. Ninety four percent of consultants working in the acute public hospital system are employed under contracts that permit them to engage in privately remunerated medical practice in public hospitals.

Consultant recruitment and retention

The Irish health service has been uncompetitive in recruiting and retaining consultants for some considerable years due to the State and employer breaches of contract terms. Currently there are 400 (15%) of the approved Consultant posts that are vacant or which cannot be filled on a permanent basis.

The proposal will cause an exodus of experienced Consultants and doctors due the devastating effect on our international competitiveness in recruiting and retaining consultants. Currently, Ireland has one third to a half of the number of Consultants it needs on a specialty basis and this will deteriorate sharply if the proposal is implemented.

It will drive a significant portion of Consultants to change to a part-time commitments in the public hospital system, or move to a private hospital or practice abroad.

Operational matters including specialist services

It will also mean that public hospitals will not be able to maintain or expand existing levels of specialised care. Ireland's population is not large enough to support a public hospital system and totally separate, distinct private hospital services across the full suite of complex services that are currently concentrated in public hospitals. The proposal will also severely limit the scope for the development of new services and remove the impetus for public hospitals to continue to provide and develop the most advanced treatments available.

Practical approaches, timeframe and phasing

It would be both unwise and inappropriate to consider approaches for the phased removal of private practice from public hospitals. The comprehensive and detailed analysis of the adverse and unintended consequences contained in this submission make it clear that there are no practical approaches, whether phased or otherwise, that could be successfully implemented without severely undermining the delivery of acute hospital care to patients and creating an unprecedented Consultant recruitment and retention crisis.

Introduction

The Irish Hospital Consultants Association (IHCA) represents 85% of hospital consultants working in Ireland. The Association welcomes the opportunity to make a submission to the Independent Review Group on the proposal to remove private practice from public hospitals as contained in the Sláintecare Report published in May 2017.

This submission demonstrates how the proposal, if implemented, will have far reaching adverse and unintended consequences for the delivery of public hospital services in Ireland. It also outlines the considerable benefits associated with private practice in public hospitals which will be forfeited if the proposal is implemented. The Association would welcome a meeting with the Review Group to discuss its submission.

1. Background

1.1 Acute Public Hospital System

The public acute hospital system is comprised of 49 specialist and general hospitals which had 10,592 acute inpatient beds (down 13% compared with 2007) and 2,140 day case beds in 2016. In 2016, there were 635,353 inpatient discharges and 1,056,656 day cases. The system dealt with 1,296,571 Emergency Department attendances and 3,327,526 outpatient attendances.[i]

In comparison with OECD averages, Ireland's public acute hospital system compares poorly in terms of bed capacity, bed occupancy levels and number of specialist doctors per capita. The difficulties and challenges faced by the public acute hospital system, including excessively long waiting lists and ED overcrowding, are not caused by public or private patients or the staff in public hospitals. They are a consequence of years of underfunding and under-resourcing in the public system which have severely restricted and reduced the capacity of public hospitals to provide timely, high quality care to an ever increasing number of patients. Despite significant capacity deficits, due to new clinical care programmes developed by Consultants, the number of patients treated in the public acute hospital system has increased over the past 10 years by 22%. However, the increase in demand shows no sign of abating. The October 2017 ESRI report projects a 37% increase in demand for acute hospitals services in Ireland by 2030 as outlined in detail below in Appendix 2.[ii] This will increase the cost base and funding requirements of the public acute hospital system and the Exchequer and must be taken into account when considering any proposals that impact on public hospital funding.

1.2 Private Hospital Sector

Excluding psychiatric facilities, the private hospital sector is comprised of 18 acute hospitals which had 1,907 acute inpatient beds and 581 day case beds in 2016.[iii] It is generally accepted that private hospital services are focussed predominantly on diagnostics and elective inpatient/day case procedures, for patients presenting with lower acuity illness. There is a significant number of specialty services that are provided almost exclusively in the public hospital system including emergency care, cancer care, geriatrics, ICU care, maternity care, paediatrics, organ transplantation, stroke care, neurology and complex surgery, etc. Typically these are high-cost, complex services requiring a high concentration of specialist expertise and equipment that the private sector has traditionally chosen not to provide for commercial reasons. Private hospitals have severely limited capacity for Intensive Care. Just half of the private acute hospitals operate an Emergency Department or a Medical Assessment Unit which in total see approximately 52,000

patients per annum and admit approximately a quarter of those patients presenting.[iv] In comparative terms, the activity of the private hospital sector in dealing with emergency and non-elective, acutely ill patients is just a small fraction compared with the public hospital system. There is no evidence to suggest that the private sector has the capacity to provide care for the significant cohort of privately insured patients that currently choose to attend at public hospitals for a wide range of specialist services.

1.3 Private practice in public acute hospitals

Ninety four percent of all consultants working in the acute public hospital system are employed under contracts that permit them to engage in privately remunerated medical practice in public hospitals. Consultant contracts have evolved over decades with the aim of increasing Ireland's competitiveness in the recruitment of high calibre internationally mobile specialists while taking account of the relatively high percentage of the population with private health insurance.

In terms of private practice levels, HSE data for September 2017 shows that privately insured patients represented just 18% of all inpatient discharges and just 14% of day case admissions. These levels are well within the typical 80:20 and 70:30 ratios provided for in consultant contracts.[v]

Over 82% of all inpatients discharges in 2017 were patients admitted through the emergency department.[vi] [vii] These patients are treated strictly on the basis of clinical need. There is therefore no basis for the misconception that privately insured patients bypass queues for care in the emergency departments of public hospitals.

Just under 18% of all inpatient discharges in 2017 were elective. However, private patients admitted on an elective basis account for less than 4% of all public hospital admissions.

It is clear that private patients are not disproportionately represented in obtaining care in public hospitals, bearing in mind that 45% of the general population has private health insurance cover. In fact, the contrary is clearly the case based on the data. Privately insured patients do however have a significant positive effect on hospital income, contributing some €649m per annum, equivalent to 15% of the overall public acute hospital budget.

1.4 Private health insurance and patient choice

There were 2.17m people with inpatient health insurance plans at the end of September 2017 representing 45% of the general population.[viii] Approximately one third of those with private health insurance are in the C2 or DE social classes.[ix] Therefore, membership of private health insurance schemes spans most of the spectrum of socio-economic strata in this country excluding the 33% with medical cards. Ireland's existing system of private health insurance is a voluntary one based essentially on a personal decision to participate.

A significant and increasing cohort of the general population has elected, to avail of privately funded health services, whether delivered in the public system or in the private sector. It is important that patients are facilitated in doing so into the future to guarantee the financial viability of the public hospital system.

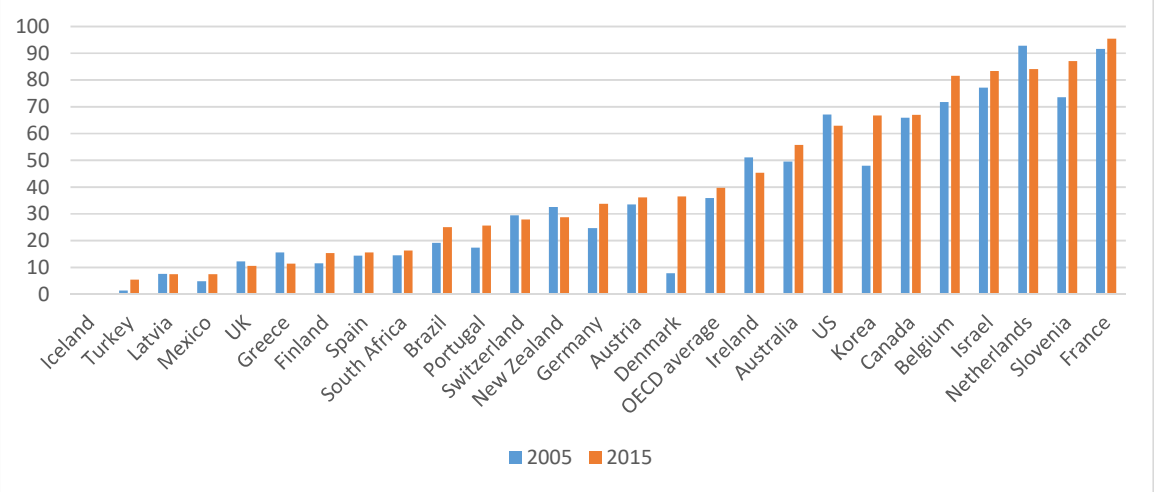
1.5 The Public/Private Mix in other jurisdictions

There is a misconception that Ireland is an outlier among other countries by virtue of the public/private mix within its public hospital system. In fact, Ireland is far from unique in this regard.

Firstly, Ireland is not unusual in that its public acute hospital system is financed from a combination of funding including general taxation, social insurance, private health insurance and out of pocket payments, similar to the model employed in many other OECD countries.

Secondly, it is evident from figure 1 below there is an overall trend for significant uptake levels in private health insurance among most OECD countries.[1] In addition, most countries have maintained or increased levels of participation in private health insurance over the past decade.

Figure 1: Trends in private health insurance coverage, 2005 and 2015 (or nearest year)



Source: OECD Health Statistics 2017

Thirdly, there are many other examples of public health systems that facilitate private practice in public hospitals in other EU countries, Australia and other jurisdictions. It is widely acknowledged that there are benefits associated with facilitating private practice in public hospitals.

The Department of Health's White Paper on Private Health Insurance in 1999 identified five significant advantages and benefits of the public and private mix of hospital services which remain valid today. These include:

- *It represents an additional income stream to the public hospital system;*

[1] According to the OECD definition, private health insurance comprises insurance schemes financed through private health premiums, i.e., payments that a policyholder agrees to make for coverage under a given insurance policy, where an insurance policy generally consists of a contract that is issued by an insurer to a covered person. Take up of private health insurance is often, but not always, voluntary (it may also be compulsory for employees as part of their working conditions). Premiums are non income-related, although the purchase of PHI by a specific population group or by the population at large can be subsidised by the government.

- *It helps to ensure that medical and other professional and technical staff of the highest calibre continue to be attracted into, and retained in, the public system;*
- *It promotes more efficient use of consultants' time by having public and private patients on the same site;*
- *It facilitates active linkage between the two delivery systems in terms of the dissemination of current medical knowledge and best practice;*
- *as accident and emergency services are primarily provided by the public hospital system, it enables patients to avail of private healthcare when admitted to public hospitals on an emergency basis;*

It continues to be a significant benefit to the State and public hospitals that insured individuals fund the cost of their own healthcare in public acute hospitals and private hospitals. It is not realistic for the public hospital system to be exclusively dependent on the Exchequer for the entirety of its funding. It is more effective to have a range of funding sources given the significant need to expand public hospital capacity. Private care in public hospitals provides significant additional funding which underpins acute capacities that would otherwise have to be funded through general taxation. It also ensures that a gulf in standards does not exist between public and private systems. The public/private mix therefore enhances the overall quality and sustainability of the public acute hospital system.

The facilitation of private practice in public hospitals is a key component in attracting and retaining Consultants in Ireland. Without it, public hospitals will become uncompetitive given the strong international demand for mobile Consultants. Further details are included in this regard in section * below.

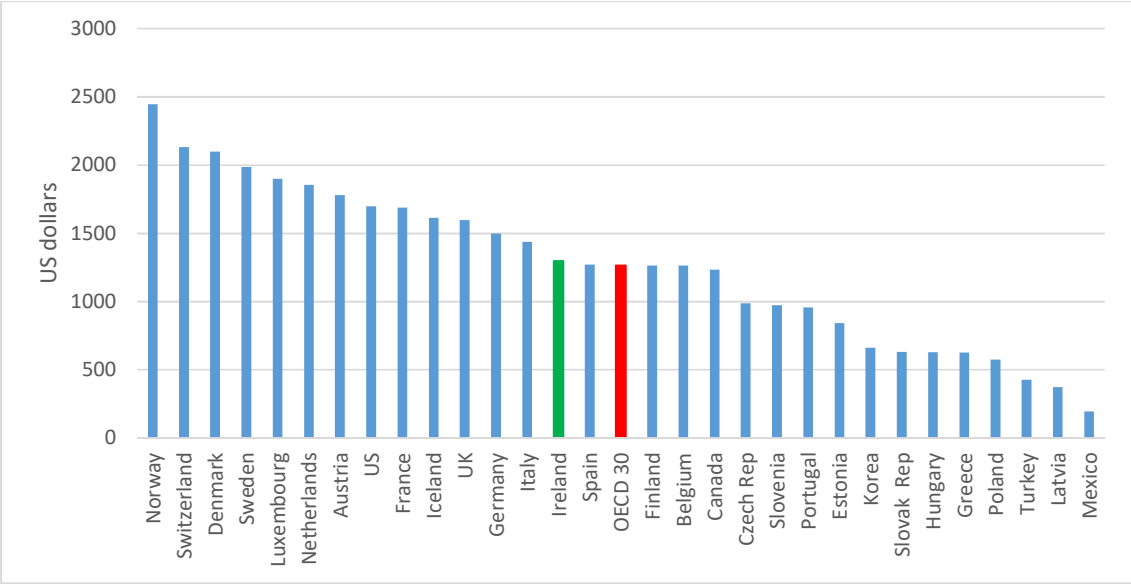
The public/private mix facilitates patient choice. The 45% of the population with private health insurance should be facilitated in accessing and utilising their insurance in public hospitals if that is their preference. Privately insured patients are dependent on the public hospital system for services that are not generally available in private hospitals. These include but are not limited to obstetrics, paediatrics, acute cardiology, all transplantation services, advanced vascular surgery, neurology and major surgery for advanced cancer.

2. Funding Arrangements

The proposal to remove private practice from public hospitals and the associated loss of income must be assessed against a backdrop of severe and perennial public hospital under-funding, consistent annual financial deficits and demands on acute hospital budgets arising from demographic changes and other cost increasing factors. Appendix 1 includes a comprehensive analysis of the consistent underfunding of the public acute hospital system and the annual deficits that have occurred in the past decade.

While commentators have indicated that expenditure on the total health service in Ireland is among one of the highest in the OECD, comparisons based on acute hospital expenditure show that Ireland is close to the OECD average. Figure 2 compares Government/Compulsory Scheme expenditure on all functions in acute hospitals. On a per capita basis adjusted for purchasing power parity, Ireland's expenditure is equivalent to the OECD30 average. It is well below the level of funding provided in other developed countries against which acute hospital services here are compared.

Figure 2: Government/compulsory schemes, Current expenditure on health (all functions), Hospitals, Per capita, current prices, current PPPs.



Source: OECD.Stat 2015

Ireland also has had a lower level of capital investment in its acute hospital system compared with other developed western European countries as demonstrated in figure 7 in Appendix 3.

The relatively low levels of funding directly impacts on the capacity and effectiveness of our acute hospitals to deliver care to patients.

The costings included in the Sláintecare Report purport to show the cost implications of implementing all 23 of the Report's proposals to expand entitlements over a 10 year period. The Association is extremely concerned that the Report's presentation significantly underestimates the level of additional funding that will be required. Details of the Association's analysis are included in Appendix 5.

In summary:

- The Report incorrectly identifies €2.8bn as the cost of implementing all 23 proposals over a 10 year period. In fact, €2.8bn is the cost of implementing the proposals in year 10 alone. The true cumulative cost of implementing the proposals over the initial 10 year period on a phased basis is €19.8bn, with the cost increasing to €28bn plus inflation in subsequent decades.
- In respect of private practice specifically, the Report incorrectly identifies €649m as the cumulative cost of implementing the proposal over a 10 year period. In fact, €649m is the cost of implementing the private practice proposal in year 10 alone. The true cumulative cost of implementing the private practice proposal over the initial 10 year period is €4.5bn based on the Report's phasing schedule. The Association believes that the real 10 year cost will be €6.5bn in static terms and €8bn adjusted for inflation. Therefore, the real cost will be closer to €800 million per year when fully implemented.

Furthermore, the Report's costings do not take account of the full effects of anticipated demographic changes or medical inflation. Similarly, the cost of the capacity expansion in the recently announced Bed Capacity Review was not included in the Slaintecare Report.

It defies logic that the public acute hospital service would seek to forfeit €650m to €800m in private practice income per year at a time when it is struggling to secure sufficient funding for the current level of service. It is also inconsistent for government policy to simultaneously propose reductions in taxation and at the same time discard this quantum of income, which is ostensibly to be replaced by increased Exchequer funding. These inconsistencies are especially a concern in view of the need to significantly expand public hospital funding and capacity as acknowledged in the Health Service Capacity Review.

The proposal will inevitably result in larger acute hospital budget deficits and have a devastating effect in terms of the financial viability of public hospitals and their capacity to treat an ever increasing number of patients. Consequently, there would be much greater reliance on supplementary budgets funded by the Exchequer or alternatively a reduction in the level of acute hospital services, leading to longer waiting lists and increased hospital ED overcrowding.

The proposal will not create additional capacity or reduce the number of patients requiring public hospital care. Patients who heretofore rely on their health insurance to receive treatment in public hospitals will continue to present in those hospitals, as is their right, even if the acute hospitals lose the capacity to charge the health insurers who provide cover to such patients. In effect, the public hospital system will continue to treat privately insured patients but forfeit the benefits of current health insurance revenue that is currently a core element of the funding for the delivery of acute care in public hospitals.

The proposal to remove private practice income from public hospitals will have an adverse impact on the capability to provide much needed capital investment. As outlined in Appendix 3, there is a growing need for increased capital investment in the acute hospital system and this is unlikely to be properly fulfilled by the State over the coming years, even without the implementation of the private practice proposal. Inevitably, there will be less scope for the required level of capital investment and related operational funding in circumstances where the acute hospital system becomes an even bigger burden on the State for its day to day funding. The acute hospital system will be competing for Exchequer funding with housing, education, social protection, national debt servicing and other requirements. It is clear that the Sláintecare Report's presentation of the cumulative cost of implementing the proposal has been severely understated. The true cumulative spend to implement the proposal on private will be between €6.5bn and €8bn in 10 years.

Based on experience in recent decades and the challenges impacting on the national finances, the IHCA and its hospital consultant members have no confidence that the loss in private health insurance income will be replaced by the Exchequer. In a recent survey of IHCA members, the vast majority confirmed that the proposal would have a negative or very negative impact on the adequacy of funding and resourcing to provide timely care to patients in their public hospitals. The State has for decades failed to adequately fund the public acute hospital system. This is particularly a concern given the existing level of public acute hospital operating and capital underfunding and when consideration is given to the existing overwhelming capacity deficits and the ESRI projected increase in demand for care and resourcing by 2030 (see Appendix 2).

3. Eligibility, Access and Equity

Since 1991, all citizens in Ireland have been eligible for treatment in public hospitals. That remains the case regardless of whether private practice is facilitated or removed from public hospitals. The proposal will not improve or increase eligibility for patients in acute public hospitals.

The perception of inequity arises from the significant delays that patients encounter when trying to access care in the public hospital system. Access is being severely restricted because of the capacity deficits are preventing public hospitals delivering timely care to patients. If there was sufficient capacity in the public hospitals then all patients would consistently have timely access to high quality care and this would remove any perceived inequity. However, this requires significant additional funding and capital investment.

The proposal will not improve access or increase capacity in the system. Quite the contrary. It will actually reduce public hospital access as the loss of between €650 million and €800 million in health insurance income per year will severely constrain the range of services public hospitals provide.

The proposal will also reduce access to specialised clinical services for patients in public hospitals because it will severely exacerbate the current Consultant recruitment crisis and cause an exodus of experienced Consultants who will not be replaced. Further details are included in Section 5 below in this regard.

Public hospitals access will deteriorate compared with that available in private hospitals. As a result it will give rise to a more inequitable, extreme two-tiered acute hospital system. Patients in public hospitals will be treated in an under resourced and overcrowded public system while privately insured patients will have access to a functioning and adequately resourced private hospital sector. This will not improve equity nor is it desirable.

The proposal will create inequity and reduced access for all patients who need public hospital care. It will disenfranchise that proportion of the general population, currently 45%, that holds private health insurance from obtaining care in public hospitals, while simultaneously undermining quality of care and access for all hospital patients. It will not be possible for the vast majority of privately insured patients, who heretofore have obtained their treatment in public hospitals, to access the range of care that they require in private hospitals. There is also no evidence to suggest that private hospitals have the capacity that would be required to accommodate such an influx of insured patients from the public hospital system.

The proposal will inevitably drive increased costs in the public and private acute hospitals systems. If private patients are forced out of the public hospital system to obtain their care in the private sector, it will impact adversely on current efficiencies derived from concentrating aspects of care in certain public hospitals. In addition, the increased demand for an expanded range of care will drive up the cost of private patient care overall in view of market supply and demand dynamics. The increased cost will thereby undermine the sustainability of private health insurance for a cohort of the population and ultimately will increase the burden on public hospitals. The end result will be higher private patient costs and a poorer public health service with the loss of some €800m per year in much need public hospital income.

There is no evidence to suggest that the removal of private practice income would increase the number of patients that public hospitals care for in future.

In a recent survey of IHCA members, the majority confirmed that the removal of private practice, if implemented, will have a negative or very negative impact on the capacity of their public hospitals to treat more patients. As well as inpatient and day case services, members confirmed that it will adversely impact on patient access to outpatient clinics in their hospitals or service.

4. Legislative and Legal issues

The proposal will create significant difficulties from a legal perspective and an industrial relations perspective. Ninety four percent of consultants working in the acute public hospital system are employed under contracts that permit them to engage in privately remunerated medical practice in public hospitals.

There is no evidence that Consultants currently employed in the public hospital system wish to change to 'public only' contracts. While 'public only' contracts offer a marginally higher salary, just 6% of the consultant body are employed under this contract. The HSE adopted a policy in March 2011 of offering only Type A 'public only' contracts for all new consultant posts. The contract proved to be highly unattractive as evidenced by the fact that the HSE and hospital employers failed to fill the posts advertised during the period in question. The policy was subsequently abandoned.

5. Consultant recruitment and retention

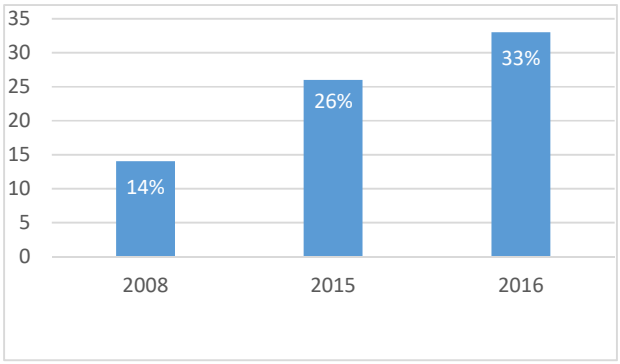
The terms of reference for the Independent Review Group require it to assess the proposal having regard to the concern highlighted in the Sláintecare Report that *"any change should not have an adverse impact on the recruitment and retention of consultants … in public hospitals."* Any such assessment must therefore take account of the ongoing and deteriorating consultant recruitment and retention crisis.

The Irish health service has been uncompetitive in recruiting and retaining the number of experienced consultants it requires for some considerable years. The extent of the crisis is clear from a review of the stark statistics on unfilled consultant posts.[x] Figures for 2015 revealed that of the 148 PAS advertised Consultant posts, one in four failed to attract any suitable candidates. There were no applicants for 20 posts (13.5%) and a further 56 (38%) receiving either one or two applicants.[xi,xii] This means that more than half of all advertised posts in 2015 received zero to two applications, thus restricting the range and calibre of candidate choice available to hospital employers. The situation has deteriorated with the HSE failing to fill a third of consultant posts it advertised in 2016, being "unable to identify a suitable candidate" for 30 of the 92 posts it advertised. [xiii] Nearly 60% of advertised posts received between zero and two applications.

In 2016, both the percentage of unfilled posts and percentage of posts receiving zero to two applicants increased, deepening the recruitment crisis further.

Overall, Ireland's ability to compete internationally for consultants has deteriorated since 2008, which was a relatively poor recruitment year due to the failure to clarify aspects of the Contract which was under negotiation and not honoured once agreed. The percentage of unfilled posts in 2008 was 14%. By 2016, this percentage had grown to 33% representing more than a two fold increase.

Figure 3: % Consultant Posts Advertised and Unfilled

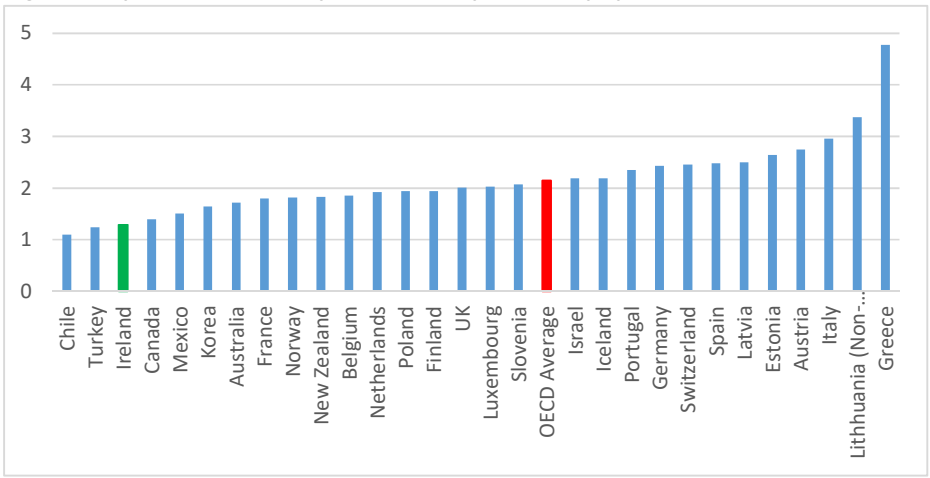


***Source**: Public Appointments Service - *Includes 7 posts withdrawn by the HSE in 2016.*

There are 3,020 'approved' permanent consultant posts of which 2,600 are filled permanently.[xiv] The number of permanently filled posts is 1,000 below that recommended in the Hanly Report in 2003. When the higher population growth and demographic changes since 2003 are taken into account, a revised Hanly figure should now be set significantly higher, at around 4,300 consultants.

Based on International comparisons Ireland has the third lowest number of consultants on a population basis in the OECD. In order to achieve the OECD average, Ireland would need to recruit an additional 4,000 Consultants.

Figure 4: Specialist medical practitioners per 1,000 population in OECD in 2015



Source: OECD Health Statistics

ESRI projections indicate a 37% increase in the need for inpatient and day case capacity by 2030. The projected additional demand can only be satisfied by the appointment of a much increased number of consultants. It will not be possible to recruit the required number of consultants in a global competitive market place if the State and health service employers repeatedly breach the terms and conditions of the 2008 Consultant Contract.

The appointment of doctors who are not registered as specialists with the Medical Council to fill specialist Consultant posts highlights the extent of the recruitment crisis. The HSE confirmed that81 consultant

post-holders appointed since March 2008 do not hold specialist division registration. These appointments are in breach of the HSE's recruitment rules and the Medical Practitioners Act, 2007.

If implemented the proposal will cause an exodus of experienced Consultants and create an unprecedented recruitment and retention crisis. Many experienced Consultants will leave the public hospital system if the proposal is implemented.

Already there are 400 (15%) of the approved Consultant posts which are vacant or cannot be filled on a permanent basis. The proposal will have precisely the opposite effect to the Report's stated aspiration that we must create the conditions where "*we attract high-calibre applicants back to all health service positions, including consultant posts*". In a recent survey of IHCA members, the vast majority confirmed that the proposal to remove private practice from public hospitals would have a negative or very negative impact on the retention of consultants currently working in Ireland and the recruitment and retention of new entrant or recently qualified specialists to work in Ireland.

The proposal will serve only to increase the number of approved Consultant posts that will be vacated and cannot be filled. It will act as a massive disincentive to Consultants taking up public hospital posts. It will drive a significant proportion of Consultants to take up only part-time or sessional commitments in the public hospital system, or move to a private hospital or practise abroad.

6. Operational matters including specialist services

Public hospitals will not be able to maintain or expand existing levels of specialised care in areas as emergency care, cancer care, geriatrics, ICU care, maternity care, paediatrics, organ transplantation, stroke care, trauma care, neurology and complex surgery. At current levels, Ireland's population is not large enough to support a public hospital system and a totally separate, distinct private hospital services across the full suite of complex services currently concentrated in public hospitals. Indeed there are significant economic benefits from integrating the two systems rather than attempting to operate two parallel and distinct health care systems in a small country such as Ireland.

In a recent survey of IHCA members, the vast majority confirmed that the proposal to remove private practice from public hospitals would have a negative or very negative impact on the range and extent of specialist services that could be maintained in their public hospitals. Significant added value and synergy arises from having private practice in public hospitals which provide care to patients with multiple comorbidities and high levels of acuity. This requires the retention of high level skills and specialist services in the public hospital system which will be undermined if this proposal is implemented.

7. Practical approaches, timeframe and phasing

The Association notes with concern that the terms of reference for the Independent Review Group's review extend to the consideration of transitional arrangements, time frames and phasing for the removal of private practice. The Association believes that the review should be confined to an assessment of the adverse and unintended consequences of the proposal, as required by the Sláintecare Report. It would be both premature and inappropriate to consider transitional arrangements in the absence of full consideration by all stakeholders of the adverse and unintended consequences that would inevitably flow from implementation of the proposal.

As outlined above, these adverse and unintended consequences include but are not confined to:

- The removal of between €6.5bn and €8bn in private health insurance income per decade. This will result in larger acute hospital budget deficits and have a devastating effect on the financial viability and the capacity of public hospitals to treat an ever increasing number of patients.
- An unprecedented Consultant recruitment and retention crisis and an exodus of Consultants thereby reducing the availability of highly specialised clinical services to patients in public hospitals.
- Reduced public hospital capacity and access for all patients.
- An adverse impact on much needed capital investment. There will be less Exchequer scope to fund the required capital investment in circumstances where the acute hospital system becomes an even bigger burden on the State for its day to day funding.
- A more inequitable and extreme two-tiered acute hospital system. The proposal will create inequity and reduced access for all patients who need public hospital care. It will disenfranchise that proportion of the general population that holds private health insurance from obtaining care as needed in public hospitals.
- Significant and extremely damaging difficulties from legal and industrials relations perspectives. Ninety four percent of consultants working in the acute public hospital system are employed under contracts that permit them to engage in privately remunerated medical practice in public hospitals.
- An adverse impact on the ability of public hospitals to maintain and expand existing levels of specialised care. Ireland's population is not large enough to support a public hospital system and a totally separate, distinct private hospital services across the full suite of complex services currently concentrated in public hospitals.

In the circumstances, it would be both unwise and inappropriate to consider approaches for the phased removal of private practice from public hospitals. The comprehensive and detailed analysis of the adverse and unintended consequences contained in this submission make it clear that there are no practical approaches, whether phased or otherwise, that could be successfully implemented without severely undermining the delivery of acute hospital care to patients and creating an unprecedented Consultant recruitment and retention crisis.

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[i] Health in Ireland, Key Trends 2017, Department of Health

[ii] ESRI, 'Projections of demand for healthcare in Ireland, 2015-2030: First report from the Hippocrates Model'

[iii] Health in Ireland, Key Trends 2017, Department of Health

[iv] Submission by the Private Hospitals Association to the Oireachtas Committee on the Future of Healthcare, August 2016

[v] Presentation to the Joint Oireachtas Committee on Health by Ms Teresa Cody, Assistant Secretary, Department of Health on 13th December 2017.

[vi] HSE September 2017 Management Data Report, August 2017 (YTD) data

[vii] Opening Statement to the Joint Committee on Health by Mr Liam Woods, National Director, HSE Acute Hospitals Division on Wednesday, 13th December 2017

[viii] Based on CSO population estimates

[ix] Health Insurance Authority, Review of Private Health Insurance in Ireland 2016, conducted by Millward Brown

[x] Document released by the PAS to the *Sunday Business Post* and published online on 12th November 2017.

[xi] 'Towards Successful Consultant Recruitment, Appointment and Retention', HSE, February 2017, p6.

[xii] 'New figures reveal hospital consultant hiring crisis', *Sunday Business Post*, May 29, 2016.

[xiii] Ibid.

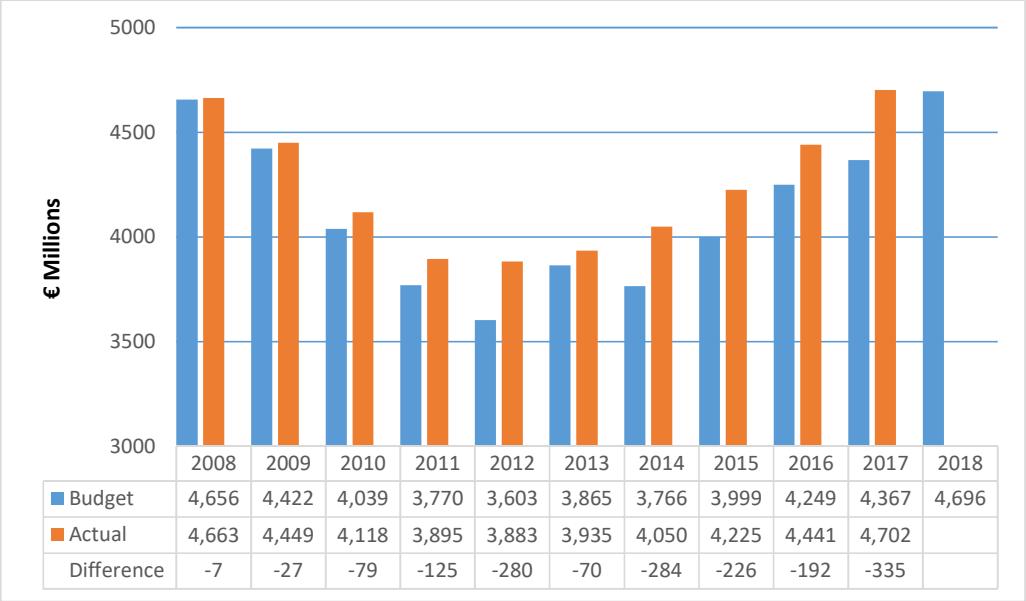
[xiv] DoH & HSE Response No. 1, Joint Committee on Health, October 18, 2017.

Appendix 1

Underfunding and Annual Deficits in the Budget for Public Acute Hospitals

There was an average annual deficit of €231.17m between 2012 and 2017. The acute hospital budget of €4,696 for 2018 is €6m (0.1%) lower than the estimated actual expenditure of €4,702m incurred in 2017.

Figure 5: *Current Acute Hospital funding 2008 - 2018*

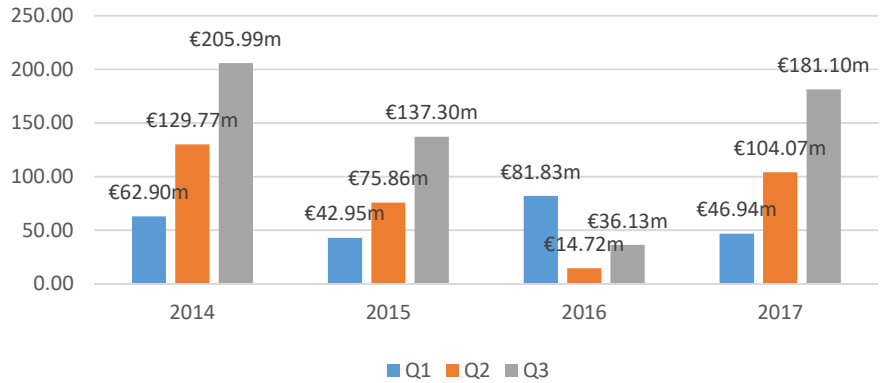


	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Budget	4,656	4,422	4,039	3,770	3,603	3,865	3,766	3,999	4,249	4,367	4,696
Actual	4,663	4,449	4,118	3,895	3,883	3,935	4,050	4,225	4,441	4,702	
Difference	-7	-27	-79	-125	-280	-70	-284	-226	-192	-335	

Source: *HSE Performance Reports & HSE Annual Reports & Accounts and Estimates of Public Expenditure (2008 - 2017)*

In the third quarter of 2017, the overall acute hospital expenditure was 5.45% over budget with all but one of the country's 49 acute hospitals reporting budget overspends.

Figure 6: *Variance in Acute Hospital spend/funding 2014 - 2017 (July - Sept)*



Source: HSE Performance Reports (2014-2017). Note: Q2 2015 is May figure as HSE Performance Reports for June 2015 not available

As occurred in previous years, the unrealistic funding provided to the acute hospitals on a near continuous basis has institutionalised health care rationing. Rationing has become acceptable practice in Irish health care.

Appendix 2

Cost increasing factors in the public acute hospital system

1. Increased demand

The ESRI's recent report published in 2017 provided annual projections of demand for public and private health and social care services in Ireland for the years 2015 to 2030 as follows.[1]

The report projects:

- Population will grow by up to 23%, or 1 million people, with the numbers of those over 85 projected to almost double
- Demand for public inpatient bed days are projected to increase by between 32% and 37% by 2030
- Demand for public day-patient cases to increase by 23%-29%
- Demand for private hospital inpatient bed days to increase by 28%-32%
- Demand for private hospital day-patient cases to increase by 24%-28%

Such additional projected demand will naturally give rise to a need for expanded capacity and staffing throughout the acute hospital service, and in particular additional consultant posts. These projected increases in the need for inpatient and day case care will of course be paralleled by an increase in the cost base of the public acute hospital system. Given that the current acute hospital budget is €4.3bn annually, an increase of 37% in the demand for inpatient and day case care, even without any consideration of medical inflation means that the budget would have to be increased to €5.9bn by 2030. This additional funding will be required to deliver care to a contemporary standard in future years, but will undoubtedly increase with the adoption of innovative medical practice and medical inflation. Furthermore, this projected increase in funding must be viewed in the light of the current financial status of the health system, where the HSE considers that there will be a shortfall in funding for the overall health service in the order of €900 million for 2018. To compound matters, the HSE has projected that there will be an average annual demographically driven cost pressure of approximately 1.8% per annum to 2022, reflecting the acceleration in population ageing.[2]

2. Medical Inflation

In parallel with increased demand for care, there are ongoing increases in the level of costs associated with providing care. Gross medical inflation in 2017 was 1.3% and has traditionally always outpaced general inflation.[3]

3. Increased payroll costs

The reversal of salary cuts imposed under FEMPI legislation increased payroll costs by €118m for 2017. The 2018 FEMPI reversals amount to 1% of payroll in January and another 1% in October further increasing costs. Further FEMPI salary cuts are scheduled to be reversed in the period to 2021.

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[1] ESRI, 'Projections of demand for healthcare in Ireland, 2015-2030: First report from the Hippocrates Model'

[2] 2017 HSE Report – Planning for Health: Trends and priorities to inform Health Service Planning

[3] Source: Central Statistics Office

Appendix 3

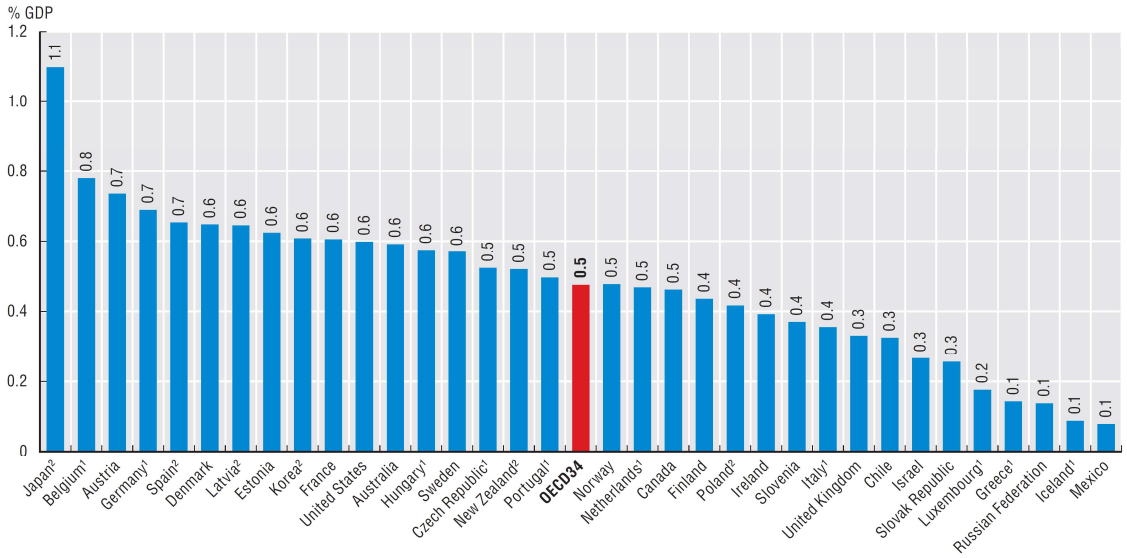
Capital Investment Requirements

The capacity of Ireland's acute public hospital infrastructure to effectively meet existing and projected levels of demand for care is and will be determined by two key parameters, namely the extent to which it is properly funded for day to day frontline operations and the extent to which it receives the required levels of capital investment to ensure the necessary capacity is in place. With regard to the former, an assessment of day to day funding issues has been outlined above in the preceding Appendices.

With regard to the latter, it should be noted that, aside from income and funding for day to day frontline operations, the Sláintecare Report does not adequately address the capital investment requirements of our public acute hospital system.

Based on OECD data, capital health care funding in Ireland at 0.4% of GDP compares unfavourably with capital funding in other EU countries. The OECD34 average is 0.5% GDP, while most developed countries spend between 0.6% and 0.7% GDP per annum (see figure 7 below).

Figure 7: Gross fixed capital formation in the health care sector as a share of GDP, 2015 (or nearest year)



Source: OECD Health at a Glance 2017

The Association is concerned that the additional 0.3% GDP, or €600 million annually assuming a GDP of €200bn, will not be resourced adequately from the Exchequer. Over the course of the 10 year period proposed for implementation of the Sláintecare Report, this necessary expansion in health care capital funding amounts to almost €6bn or a total healthcare capital budget of up to €1.4bn per year, equivalent to €14bn over a 10 year period.

The existing Capital Plan provides approximately €3bn in funding for the entire health service for the period 2016 to 2021. This is €2bn below the funding equivalent of that provided in 2008. In addition, there has been significant growth in the demand for health care services, especially acute hospital services in the interim. The current capital provision for the health service represents gross

underfunding in the context of the estimated cost of €1.8bn to build the new Children's Hospital and to relocate the National Maternity Hospital and the Rotunda Hospital. The balance of €1.2bn does not even fund the estimated cost of maintaining and replacing essential acute hospital equipment. In addition, it critically does not provide for a significant increase in funding for urgently required acute beds, ICU beds, theatre capacity and other essential hospital facilities.

The recent Health Service Capacity Review includes recommendations for an increase of 2,590 beds in the public system by 2031 with an immediate increase of 1,260. The recommendations in this regard fall short of the 4,000 additional beds that the Association has currently estimated to be required in order to address the significant capacity deficits in the system. Secondly, the 2,590 additional beds are predicated on achieving major reforms elsewhere in the public health system including a 50% increase in the primary care workforce and a 120% increase in homecare services. Without such reforms, the actual additional beds needed would be more than 7,000. At a time when significant capital investment will be required to implement the Capacity Review recommendations, it makes no sense for the acute hospital system to discard a substantial income stream from the delivery of private care in public hospitals thereby increasing its reliance on the Exchequer for additional funds, most likely to the detriment of increased capital spending and annual operating budgets.

Given the need for additional acute hospital funding arising from ESRI projections, and a contemporaneous need to expand capital funding to €14bn, it would be unwise to reduce the revenue of the acute hospital system by at least €6.5bn over 10 years at current prices. On the basis of health care funding alone, removing private care from public hospitals is not a pragmatic solution to the health care challenges that are anticipated over the next decade.

Appendix 4

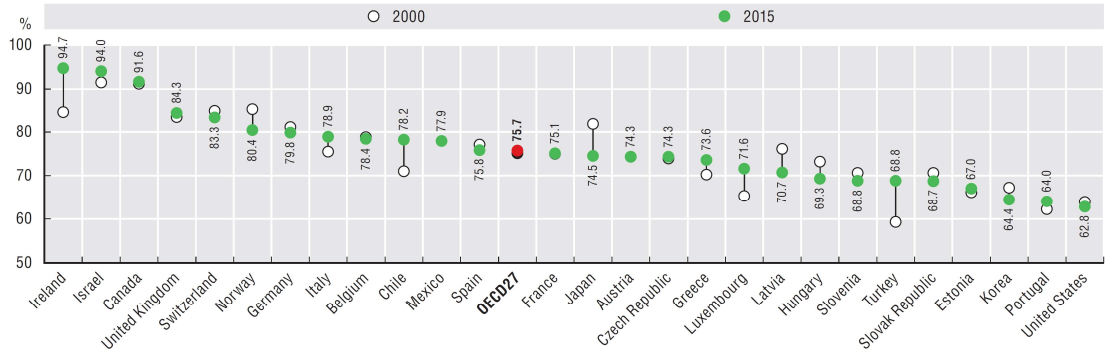
Serious Capacity Deficits in the Acute Public Hospital System

Ireland's public acute hospital infrastructure has been severely compromised over the past decade as a result of consistent budget cuts and a lack of capital investment. The consequent capacity crisis would be exacerbated by the proposed removal of private practice income.

OECD comparisons confirm that Ireland's public acute hospital system has:

- One of the lowest numbers of specialist doctors, with 1.29 specialists per 1,000 population compared with an OECD average of approximately 2.14.[4]
- The highest bed occupancy rate among OECD27 countries at 94.7% compared with an OECD average of 75.7% (see figure 8 below)
- One of the lowest numbers of acute hospital beds in the OECD at 2.4 per 1,000 of population compared with the OECD average of 3.6 per 1,000 in 2014.[5]
- Significant capacity deficits in terms of ICU beds. In 2009, the HSE commissioned Prospectus Report recommended an immediate increase of 45% in ICU beds from 289 to 418 in 2010 alone, to be followed by a further increase to 579 by 2020.
- Restrictions on timely access to endoscopy, diagnostic imaging, operating theatres and outpatient clinics
- An unacceptable number of patients being treated on trolleys which has almost doubled since 2008.[6]
- Significant problems with outdated, malfunctioning and obsolete equipment

Figure 8: Occupancy rate of curative (acute) beds, 2000 and 2015 (or nearest year)



Source: OECD Health at a Glance 2017

[4] OECD Health Statistics 2015. See Figure 4 in section 5 above.

[5] Ibid

[6] INMO Trolley Watch data 2008 to 2017

Appendix 5

The true cost of implementing the Slaintecare Proposals

Table 1 below is an extract from Appendix 3 of the Report which purports to show the cost implications of implementing all 23 of the Report's proposals to expand entitlements. The Association is extremely concerned that the Report significantly underestimates the level of additional funding that will be required to implement the proposals.

This methodology overlooks the fact that the actual increase in spending in year 2, for example, is not confined to the additional €458,673,827 inputted for that year compared with year 1. The actual increase or additional spend for year 2 compared with *current* day expenditure is €854,250,888 as it must take account of the fact that spending has already been increased by €395,577,062 in year 1. Similarly, in year 3, the actual increase for year 3 compared with current day expenditure is €1,317,756,899. By presenting the cost implications in this manner, the Report contains a thoroughly misleading underestimation of the cumulative cost of implementing all of the proposals as just €2.836bn in the 10 year period when in fact this is the just the cost of year 10 on its own.

Table 1: Extract from Appendix 3 of Sláintecare Report

Year	Increase on Previous Year	Cumulative Spend
Year 1	€395,577,062	€395,577,062
Year 2	€458,673,827	€854,250,888
Year 3	€463,506,011	€1,317,756,899
Year 4	€408,815,430	€1,726,572,328
Year 5	€411,438,882	€2,138,010,895
Year 6	€384,442,036	€2,522,452,931
Year 7	€71,404,534	€2,593,857,465
Year 8	€90,181,605	€2,684,039,070
Year 9	€75,083,430	€2,759,122,501
Year 10	€77,110,399	€2,836,232,900

In fact the cumulative cost of implementing the proposals over the proposed 10 year implementation period is much higher as confirmed by Table 2 below which is an IHCA modified and corrected version of Table 1. Table 2 more accurately reflects the actual increase in expenditure for each year of implementation compared with the *current* day level of expenditure rather than merely the increase compared with the previous year. It demonstrates that the true cumulative cost of implementing the proposals by year 10 is €19,827,872,939. Furthermore, the Report's costings do not recognise or take account of the full extent of demographic pressures or medical inflation.

Table 2: IHCA modified and corrected version of Table 1

Year	Increase on Previous Year	Increase in expenditure compared with current level (Year 0)	True Cumulative Spend
Year 1	€395,577,062	€395,577,062	€395,577,062
Year 2	€458,673,827	€854,250,888	€1,249,827,950
Year 3	€463,506,011	€1,317,756,899	€2,567,584,849
Year 4	€408,815,430	€1,726,572,328	€4,294,157,177
Year 5	€411,438,882	€2,138,010,895	€6,432,168,072
Year 6	€384,442,036	€2,522,452,931	€8,954,621,003
Year 7	€71,404,534	€2,593,857,465	€11,548,478,468
Year 8	€90,181,605	€2,684,039,070	€14,232,517,538
Year 9	€75,083,430	€2,759,122,501	€16,991,640,039
Year 10	€77,110,399	€2,836,232,900	**€19,827,872,939**

The true cost of implementing the private practice proposal

Table 3 below is an extract from the Report which purports to show the cost of implementing the proposal to remove private practice from public hospitals on the basis that the associated loss of funding to the acute public hospital system will be €649m per annum. The same flawed methodology has been applied. As presented, the Report anticipates that the acute hospital system will continue to receive €649m from private health insurance in year 1. There is therefore no additional spend or replacement of funding provided in year 1. In year 2, it anticipates that funding from health insurers will reduce by €129.8m and accordingly proposes that an additional €129.8m will be added to the acute hospital budget for that year in replacement. For years 3 to 6 inclusive, a further €129.8m is added each year and the Report concludes on that basis that the cumulative spend is therefore just €649m. This is, again, an entirely misleading underestimation of the cost associated with replacing the loss in private practice income.

Table 3: Extract from Report's 10 year budgeted costings for implementation of private practice proposal

Year	Increase on Previous Year	Cumulative Spend
Year 1	€0	€0
Year 2	€129,800,000	€129,800,000
Year 3	€129,800,000	€259,600,000
Year 4	€129,800,000	€389,400,000
Year 5	€129,800,000	€519,200,000
Year 6	€129,800,000	€649,000,000
Year 7	€0	€649,000,000
Year 8	€0	€649,000,000
Year 9	€0	€649,000,000
Year 10	€0	€649,000,000

This methodology overlooks the fact that the actual increase in spending in year 3, for example, is not confined to the additional €129.8m inputted for that year. The actual increase or additional spend for year 3 compared with current day expenditure is €259.8m as it must take account of the fact that spending has already been increased by €129.8m in year 2. Similarly, in year 4, the increase is not confined to the additional €129.8m inputted for that year. The actual increase for year 4 compared with current day expenditure is €389.4m as it must reflect the fact that there have been previous increases for years 2 and 3. The same applies in respect of years 5 and 6. And from year 7 onwards, an additional €649m in funding is required per annum to replace the funding foregone by the removal of private practice income to the hospital system.

In fact the cumulative cost of implementing the private practice proposal over the proposed 10 year implementation period is much higher as confirmed by Table 4 below which is an IHCA modified and corrected version of Table 3. The true cumulative spend to implement the proposal after 10 years would be over €4.5bn based on the phasing in the Report compared with the Report's €649m. The Association believes that this figure will ultimately be closer to between €6.5bn and €8bn when adjusted for inflation.

Table 4: IHCA modified and corrected version of Table 3

Year	Increase on Previous Year	Increase in expenditure compared with current level (Year 0)	True Cumulative Spend
Year 1	€0	€0	€0
Year 2	€129,800,000	€129,800,000	€129,800,000
Year 3	€129,800,000	€259,600,000	€389,400,000
Year 4	€129,800,000	€389,400,000	€778,800,000
Year 5	€129,800,000	€519,200,000	€1,298,000,000
Year 6	€129,800,000	€649,000,000	€1,947,000,000
Year 7	€0	€649,000,000	€2,596,000,000
Year 8	€0	€649,000,000	€3,245,000,000
Year 9	€0	€649,000,000	€3,894,000,000
Year 10	€0	€649,000,000	€4,543,000,000