Submission to the Independent Review of Private Practice in Public Hospitals

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I would like to begin by thanking the review group for the opportunity to make this submission and wishing the group well in its important work.

At this point, I think it would be worthwhile to reflect briefly on how the situation of private practice in public hospitals has come about. When the Voluntary Health Insurance Act, 1957, was enacted, the purpose of the establishment of the Voluntary Health Insurance Board was to give the top 15% of earners, who at that time did not have free access entitlements to public hospital accommodation or treatment, a means of paying for hospital care that they might need without facing undue financial hardship. This was a reasonable aim at the time. The purchase of voluntary health insurance was, of course, not limited to this group, but this was the main target group for private health insurance at the time.

However, since then, access entitlements have become universal (to public hospital accommodation in 1979 and to treatment by public hospital consultants in 1991), meaning that the original purpose of private health insurance in Ireland has no longer been valid for over two decades. Private health insurance in Ireland is now primarily supplementary in nature, providing faster access, greater choice of provider and/or superior accommodation. However, the practice of treating privately insured patients in public hospitals has continued, so it is not before time that this issue is now being reviewed.

Ireland is not unusual in having a mixture of public and private funding and delivery mechanisms for healthcare, but where it is unusual in an international context is in the degree of overlap between the two. We now have a situation whereby public patients are, in many cases, faced with long waiting times to access public hospital treatment, while private patients are being treated in public hospitals. Such public patients can now apply to be treated privately, at the expense of the State, under the National Treatment Purchase Fund, while private patients (i.e. those with private health insurance) are subsidised by the State, most notably through tax relief on private health insurance premiums.

In addition to being quite complex, this situation leads to significant equity issues. The 'holy grail' of health systems is to ensure that funding is based on ability to pay while access is based on need. The practice of treating private patients in public hospitals works against the second element of this aim.

Furthermore, a series of incentives have become embedded in the system, which favour the treatment of private patients in public hospitals. The first is the nature of reimbursement for public and private patients. Consultants are paid on a salary basis for treating public patients but on a fee-for-service basis for treating private patients. This means that a consultant who treats a mixture of public and private patients will receive no additional income for treating an additional public patient, but will receive additional income for treating an additional private patient.

Public hospitals face similar incentives, as they have traditionally been paid on a fixed budget basis (adjusted for Casemix) for public patients, but on a fee-for-service basis for private patients (although activity-based funding is being rolled out for public patients in public hospitals). Until 2013, public hospitals only received payment for the accommodation of private patients if said patients were accommodated in designated private beds. However, since 1st January 2014, public hospitals are now reimbursed for the treatment of private patients irrespective of what type of accommodation said patients receive. This has had the unintended consequence of strengthening the incentive to accommodate private patients in public hospitals.

It should be noted that a majority (approximately three-quarters) of public hospital patients are admitted through A&E departments, while the remainder are admitted on an elective basis. Anecdotal evidence suggests that some private patients admitted through this route are being charged (or, more accurately, their insurers are being charged) despite not receiving the benefits of private health insurance mentioned above (faster access, greater choice of provider and/or superior accommodation), which has knock-on consequences in terms of private health insurance premiums. In this context, it should be noted that privately insured patients also have rights to be treated as public patients, although they are being asked on admission to declare whether they wish to be considered as private patients.

It is in this context that the current review is being carried out. In this regard, I would like to raise some points that the review group may wish to consider.

Firstly, it is clear that the removal of private practice from public hospitals, as proposed by the Sláintecare report, will necessitate a renegotiation of the Consultant Contract. The RTE Investigates programme, 'Public v Private: The Battle for Care', broadcast on 21st November 2017, highlighted that only approximately 6% of hospital consultants are employed on Type A (public-only) contracts. Therefore, 94% of consultants currently have private practice rights – in some cases restricted to public hospital campuses, but in other cases encompassing off-site private practice.

The fact that there has been such a low take-up of the public-only contracts suggests that the vast majority of consultants believe that they would be better off having private practice rights. The reasons for this may not be uniquely financial, although it is likely that financial reasons are a significant driver of this phenomenon. It would be important therefore, to determine the reasons for this low take-up of public-only contracts and the causes for this will need to be addressed. (It could be argued that some of these consultants took out the Type B contracts in anticipation of co-

location, which was still a live policy issue at the time, but the counter-argument could also be made that they have had ample opportunity to change contract in the meantime.)

While this may lead to politically difficult decisions around consultants' remuneration, it is clear that the proposed reform will not be possible without buy-in from consultants. Equally however, no group of stakeholders, however important to the process, should be able to block progress on an issue of systemic importance such as this. Balancing these two issues could be challenging, but will be necessary.

If private practice is removed from public hospitals, then consultants will likely have to choose between public and private practice (unless they have separate contracts with public and private hospitals – the possibility for this will need to be considered before beginning the negotiations). In this regard, it would be worth considering the extent to which the private hospital sector has capacity for additional consultants.

Consideration of this will need to take into account the fact that, while the private work currently carried out in public hospitals will add to the demand for private hospital services, this may be mitigated to some extent by a reduction in the number of people taking out private health insurance if significant improvements are made to the public hospital system. Consumer surveys commissioned by the Health Insurance Authority have consistently shown that concerns about quality of and access to the public hospital system are significant drivers of demand for private health insurance.

It will also need to take account of possible expansion of the private hospital sector, which has some spare capacity currently but may not have sufficient spare capacity to deal with the increased volume of treatment without a lengthening of private waiting lists, which may also have an impact on private health insurance demand.

Bearing this in mind, any renegotiated consultant contract will need to offer sufficient incentives to consultants to work in the public sector rather than the private sector, or indeed abroad, given that consultant shortages are evident in other countries, leading to international competition for a scarce pool of talent.

Another issue to consider is the effect of replacing private patients in public hospitals with public patients. Previous research that I carried out with Dr. Edward Shinnick showed that private patients discharged from public hospitals tended have shorter average lengths of stay, despite having a relatively more complex mix of treatment.[1] Although the reasons for this are unclear, if a similar situation were to pertain after the removal of private practice from public hospitals, it would mean

[1] Brian Turner and Edward Shinnick (2012): Private Versus Public Age-Related Utilisation of Public Hospital Services in Ireland. *The Geneva Association Health and Ageing Newsletter*, No. 26, April 2012. Geneva: The Geneva Association.

that the number of additional public patients treated may be less than the number of private patients whose treatment would be removed from public hospitals. This may be relevant if there were to be an element of activity-based funding for consultants under any new contract, and indeed may also be relevant for activity-based funding of public hospitals.

Another issue to consider would be whether it would be permissible for privately insured patients to use their health insurance to procure better accommodation in public hospitals after the removal of private practice. Although private patients would no longer be able to receive faster access or greater choice of provider (in a public setting), it may be considered acceptable for them to get an upgrade to a private or semi-private room rather than a ward setting. If this were to be permitted then it would, at least to some extent, offset the reduction in private income to public hospitals in the event of the removal of private practice.

I hope that this submission is of use to the review group in terms of offering ideas for consideration, and I would be happy to discuss further anything contained in this submission if the review group wishes to do so.

Brian Turner

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