INDEPENDENT REVIEW OF PRIVATE PRACTICE IN PUBLIC HOSPITALS

Review Group Examining Private Practice in Public Hospitals

Submission by Vhi Insurance DAC 8th February 2018

Vhi has structured its response along the suggested lines of the Independent Review Group

- Eligibility, access and equity and impacts of change
- Legislative and legal issues
- Recruitment and retention of personnel
- Current and future funding arrangements including capacity considerations
- Operational matters including specialist services

It is worth noting that the report recommends the phased elimination of private care from public hospitals. Everyone will maintain this entitlement to access public care in public hospitals - those who have private health insurance will still be able to purchase care from private healthcare providers. The Committee also recommends an independent impact analysis of the separation of private practice from the public system in order to identify any adverse and unintended consequences on the public system.

Expedited treatment for public patients

The HSE purchases treatment from private hospitals for public patients who have been on a public waiting list over a certain period of time. The National Treatment Purchase Fund will have a budget allocation of €55m in 2018 to purchase treatment within the private healthcare sector for the longest-waiting public patients. Short term alleviation of public waiting lists is not possible without private hospital capacity.

Consultant Retention

The private sector has allowed consultants with dual contracts (ca. 60%) to work and supplement their incomes in the private sector thereby supporting the retention of highly skilled/high calibre consultants in Ireland.

Driving Cost Efficiencies

Vhi has been very active in driving cost efficiencies amongst private hospitals to help influence and contain the escalation of healthcare costs. Key elements include implementing the latest international guidelines and protocols, where customers are treated in the most appropriate and cost effective setting, and investigation based savings from Vhi's Special Investigation Unit. All of these activities reduce premium increases and support affordability which keeps members in the PMI market and reduces demand for public healthcare services.

Vhi recognises that certain objectives of the Slaintecare report relate to the improvement of equitable access and equity within the operations of public hospitals. Equitable access to public healthcare services based on clinical need is an important principle where the financial circumstances of the patient shouldn't have any influence on access. Progress has already been made on this issue through the introduction and operation of a single treatment list containing both public and private patients.

The most likely result of the removal of private reimbursement from public hospitals will be the re-labelling of private patients as public with no overall reduction in the list size. Hence equitable access and equity within the operations of public hospitals are likely to improve under the Slaintecare recommendations but it is unlikely that waiting lists will substantially reduce in length.

The removal of private practice from public hospitals will have a number of direct and indirect impacts:

- Any action which affects the PMI proposition will have a significant impact on PMI membership with direct consequences for the wider private healthcare sector and

Downgrades will have an impact on affordability across the market as a general premium price increase is required to pay for premium foregone from downgrades as claims are generally insensitive to plan downgrades. Any increase in cancellations will increase the number of individuals relying on their public entitlement in public hospitals.

- The current practice amongst certain PMI members is to manage their healthcare needs across the public and private sector. Any restriction on these practices might result in these members exclusively selecting one system over the other with positives and negatives for the public system and PMI depending on the choice made.

Minimum Benefits - The Health Insurance Act 1994 Minimum Benefits Regulations 1996

The Health Insurance Act 1994 Minimum Benefits Regulations 1996, which prescribe the minimum level of cover that a health insurance contract can provide, would require considerable amendment to remove all references to cover in public hospitals. As part of a related examination as to whether all required services would be available to persons in the absence of public hospitals, a review of key terms in the legislation such as 'prescribed health services' is required.

Consultants – Consultants Public Service Contract

Consultants Public Service Contracts would need to be substantially amended to prohibit consultants' private practice taking place in public hospitals. While this could ultimately be achievable by negotiation and agreement, issues such as prior investments in consulting rooms and long standing attachments to hospitals where practices have been built over many years would be likely to be contentious issues and could potentially give rise to arguments framed in constitutional terms.

General issues of contract law - hospital contracts

All private health insurance companies would need to renegotiate terms with all private hospitals to meet the supply of health services required by their members in the absence of access to public hospitals and a full overview of health service provision would be required.

Financial Management and Control Systems in the Health Service (the Brennan Report)[9] and the Hanly Report[10].

More recently the OECD[11] reported on the long waiting times that exist for out-patient and acute hospital services in public hospitals in Ireland based on figures from 2015 (refer Fig. 2). This report acknowledges that public hospitals are operating *"constantly at near capacity limitations"* and it suggests that resourcing – both human and physical – will be a long-term challenge for the health services.

Fig. 2

Outpatients	People waiting <52 weeks for first visit	90%
Day case	Adults, elective procedure, < 8 months	77%
In-patient	Adults, elective procedure, < 8 months	72%
Day case	Children, elective procedure, < 5 months	58%
In-patient	Children, elective procedure, < 5 months	53%
Emergency	All attendees discharged or admitted within 6 hours of registration	68%

The OECD report notes that whilst Ireland has increased its number of medical students since 2010, "*retention appears to be a concern*". It goes on to say that: "*Poor working conditions, such as understaffing of the workplace, or expectations to carry out too many non-core tasks as well as limited career prospects in Ireland were the top reasons for those planning to emigrate or pursue an alternative career*" thereby re-echoing the sentiments expressed in the HSE's report (*Towards Successful Consultant Recruitment, Appointment and Retention, 2016*) and the RCPI's report (*Training 21st Century Clinical Leaders, A review of the Royal College of Physicians of Ireland training programmes*", 2014)[12]

[9] Commission on Financial Management and Control Systems in the Health Service 2003
[10] Report of the National Task Force on Medical Staffing 2003
[11] OECD State of Health in the EU, Ireland, 2017
[12] Royal College of Physicians of Ireland, Training 21st Century Clinical Leaders, A review of the Royal College of Physicians of Ireland training programmes 2014

The number of Consultants registered with Vhi Insurance in January 2018 is set out in Fig. 5.

Fig. 5

Consultants registered with Vhi Insurance	2,625
Consultants working solely in private practice	637
Consultants with a public hospital contract, i.e. (Cat I or Cat II; Type B; Type B*; Type C)	1,988

Over the years since 2008 there has been a steady rise in the number of Consultants working in private practice only, with 435 in 2008 and 637 in 2017. As illustrated in Fig. 5, the vast majority of Consultants registered with Vhi Insurance hold some form of a public contract and if approximately 2,000 Consultants were denied the right to engage in private practice either on the public campus or off-campus (depending upon their specific contract type), this would have a significant impact on private health insurance and its attractiveness as a proposition for customers.

In addition, the State would have to address such issues as Consultant remuneration, working conditions and career prospects in the public sector if it is not to risk a mass exodus of Consultants to either the private sector or to hospitals abroad. These matters would have to be assessed, addressed and negotiated within a very short space of time because Irish Consultants are hugely valued abroad and they are quite mobile.

Vhi recommends that any re-negotiation of the consultant's contract must consider as a priority the availability of consultants to practice in private hospitals.

SECTION 4: CURRENT AND FUTURE FUNDING ARRANGEMENTS INCLUDING CAPACITY CONSIDERATIONS

One of the key Slaintecare funding questions is the extent that private activity within public hospitals transfers to private hospitals once private reimbursement is removed from public hospitals. At present public patients with PMI have a choice of payment. They can utilise their public entitlement, pay the inpatient levy or they can utilise their PMI public hospital benefits.

Once Slaintecare removes the right for patients to receive private healthcare benefits within public hospitals then patients will have to make a choice. They can utilise their public entitlement and continue to receive treatment in public hospitals which means that public hospital activity levels will not decrease. Where all members exercise their public entitlement then only PMI reimbursement will be removed from public hospitals where the Exchequer will have to pay for any funding deficit (most recently c.€590m). Alternatively the patient can elect to use their PMI benefits to instead receive treatment in private hospitals which means that activity levels in public hospitals will decrease and waiting times will reduce. However the Exchequer will still be required to pay for the increased activity based on the reductions in waiting lists.

To answer this question of whether patients will choose to receive public or private healthcare treatment it is useful to look at the scale and type of current private activity within public hospitals.

Table 1 – Private activity within public hospitals in 2016[13]

Discharge type	Discharges	Discharges %	LOS	Bed nights	Bed nights %	Bed equivalent*
Emergency	80,000	62%	6.4	512,715	69%	1,479
Elective	25,000	19%	5.9	147,433	20%	425
Maternity	24,160	19%	3.3	79,735	11%	230
	129,160			**739,883**		**2,134**
Daycase	**148,000**					

* Bed nights divided by 365 and using 95% capacity utilisation

In 2016 private patients made c.129k discharges, used c.740k bed nights and occupied c.2,100 beds in public hospitals. Emergency and maternity patients accounted for 81% of inpatient discharges and 80% of bed nights. Elective patients

[13] http://health.gov.ie/wp-content/uploads/2017/05/Trends-in-public-private-patient-activity-in-public-hospitals-May-2017.pdf
LOS are estimates based on analysis of graphs

Overall Vhi's conclusion is that the Slaintecare reforms will only serve to remove PMI reimbursement from public hospitals whilst not reducing levels of public hospital activity. Vhi is recommending that the full extent of this conclusion is investigated further as it will have a large impact on the funding of the Slaintecare reforms.

If the activity of private patients within public hospitals is to be moved then it is clear that private hospitals will first have to establish or expand services which are described further in section 5.

In the scenario that only elective activity is transferred to private hospitals then there would not be a requirement for additional inpatient beds as current private hospital inpatient spare capacity is sufficient.

Vhi is of the view that additional new private capacity will not be required as a consequence of Slaintecare as it expects very little of the current private activity in public hospitals will transfer to private hospitals.

the determination of risk equalisation scheme credits. Any expansion of private chronic disease management programmes will remove activity from public hospitals.

Some of the services listed above are tertiary services (particularly in the neurosurgical area, some specialised cardiothoracic services, particularly paediatric, and transplant services) which are required to be centralised to achieve a critical mass in order to both provide and maintain the standard of the service. Users of these services will not transfer from the tertiary level centre providing the service. As such not all of these services can be established in private hospitals.

In the past decade, Ireland has seen growth of its population from 4.2 million to 4.6 million, an increase of ca. 9% - largely attributable to an increase in life expectancy. Looking to the future, it is projected that Ireland's population of over 65's will grow at a rate of ca.60%, twice the rate at which it grew for the previous ten years[14]. Consequently, Ireland's significant population ageing will give rise to an increased burden of chronic disease for those living longer which has fundamental implications for future health and planning for the Irish Healthcare system.

Ireland's healthcare budget is only now recovering in funding terms from the cutbacks experienced over recent economic recession. Throughout this period significant system efficiencies have already been made but it is difficult to see how the healthcare system can manage the impact of our demographic changes without significant system wide changes. In this content Vhi welcomes the recommendations contained within the Slaintecare report in relation to integrated care which will join up primary care, community care and acute secondary services.

Chronic disease management is an area where the primary/community care sector has the potential to significantly improve outcomes for patients, reduce hospital admissions and acute hospital length of stay. Ireland's current 'hospital centric model' has meant that there is an over reliance on acute hospitals to provide the majority of people's healthcare requirements. Vhi welcomes the Slaintecare report's focus on relocating the care of patients from a hospital environment to a primary/community care setting which is often better equipped to meet the requirements of patients who have one or more chronic diseases.

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[14] Health in Ireland- Key Trends 2015

- There are currently 192,433 members of non-advanced plans where access to public hospitals is the primary benefit. If private practice was removed from public hospitals then these plans would have to close and the industry would seek to upgrade these members to more expensive private hospital plans. Any members who cancel their PMI policy will exclusively rely upon their public healthcare entitlements.

- Emergency and maternity discharges account for 80% of private activity bed nights within public hospitals and this activity is unlikely to move to private hospitals, only the cost will be borne by the State where previously it was borne by patients with private medical insurance. Almost all private medical insurance members who use public hospitals also have coverage for private hospitals but use public hospitals, either by choice or necessity, for some or all of their healthcare requirements. Slaintecare reforms will only serve to remove PMI reimbursement from public hospitals whilst not significantly reducing levels of public hospital activity. Vhi is recommending that the full extent of this conclusion is investigated further as it will have a large impact on the funding of the Slaintecare reforms.

- One of the most important Slaintecare reform considerations is the renegotiation of the Consultant contract. Any new contract could have serious implications for both the ability of public hospitals to recruit Consultants and Consultants to practice in private hospitals where any significant reduction in Consultants availability will have a serious detrimental impact on the PMI proposition.

- PMI is underpinned by strong regulation and complex enabling legislation. Any Slaintecare reforms which affect the services offered by public hospitals will require a large number of legislative amendments.

- Slaintecare reforms may have an impact on customers purchasing habits where proximity to private hospitals is low and the PMI proposition is reduced. These