Submission to the Independent Review Group

On

Removal of Private Practice from Public Hospitals

Impact on UL Hospital Group

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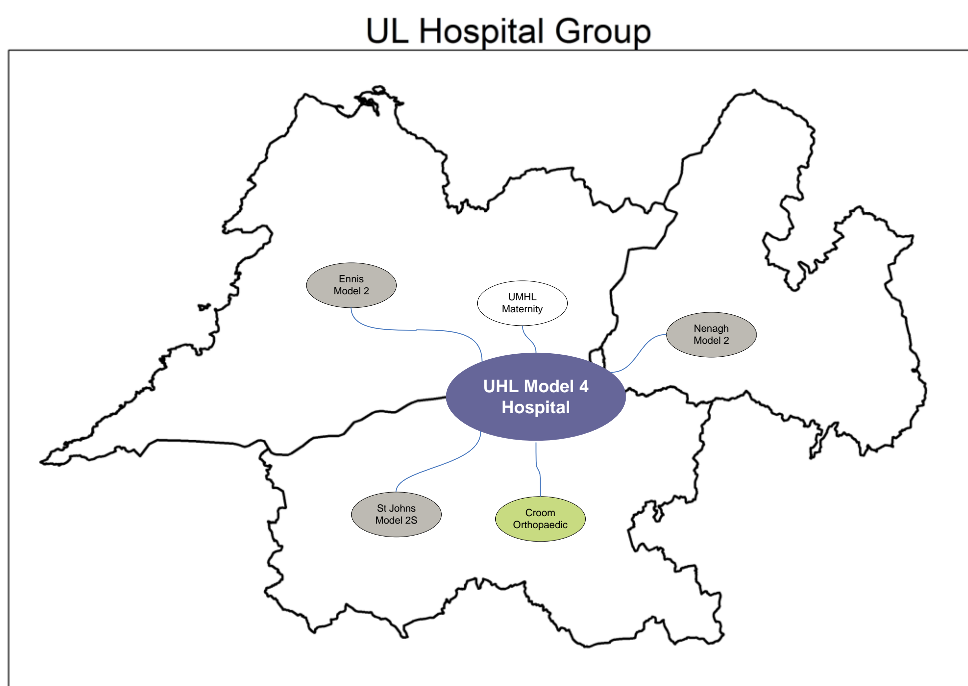
Introduction

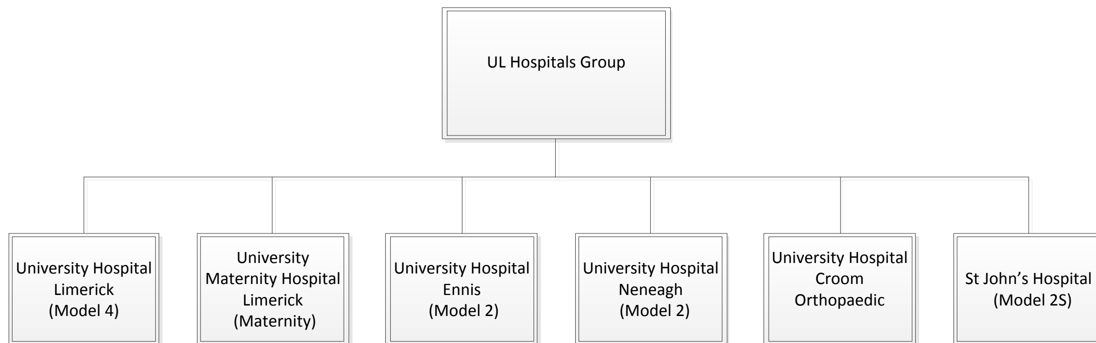
The UL hospital Group was formed following the recommendations of the Higgins report in 2013. It comprises the hospitals of the original Mid-Western Health Board region (Clare, Limerick and North Tipperary) and St John's Hospital which is a 94 bedded voluntary hospital in Limerick City.

UL Hospital Group has only one model four hospital – University Hospital Limerick (UHL) that provides 24 hour emergency services to the region (population 385,000). The other hospitals are: University Maternity Hospital Limerick, Regional Orthopaedic Hospital Croom, and three model two hospitals: Ennis General, Nenagh General, and St John's Hospital Limerick. The latter three hospitals, all have Medical Assessment (MAU) and Local Injuries Units (LIU), and function as the three spokes of the hub which is UHL. The hospital groups catchment area is the only one that is entirely co –terminus with the Community Health Organisation (CHO) for the same population.



UL hospital Group is also unique among the hospital groups in having no private hospital with significant inpatient capacity in its major urban centre. The only private hospital in the region is Barringtons Hospital Limerick, which has recently been purchased by the Bon

Secours Group who have ambitious expansion plans. This Hospital - until very recently - only accommodated inpatients on a very limited basis



Eligibility Access and Equity.

Eligibility

All Irish Citizens have the right of access to the public hospital system, and in a region with relatively little access to private hospital facilities, the demand for access to UHL for emergency services will continue to increase. **Eligibility based on income plays no role in determining admission criteria from the ED department.**

Data from the monthly health board reports of emergency admissions to University Hospital Limerick in the early 2000 showed that approximately 33% of all emergency admissions had medical insurance. Some 28% of the beds in the Regional Hospital were officially designated as private, as were 40% of the beds in St John's Hospital. These high proportions of private beds in a public hospital reflected the absence of a private hospital in the city. This same level of demand continues today.

Because of an overall lack of beds for emergency admissions, some private patients will seek care in Galway or Cork where a private ED department exists. GPs will tend to refer patients from Limerick to these facilities, if fit to travel. The removal of private practice from

the public hospital will not alter this scenario, as patients with hospital insurance who tend to attend ED in Limerick, do so for medical reasons only. Equally it should be borne in mind that with the ageing of the population and the socioeconomic demographic of the region, there is likely to be an increased demand for access to the public hospital because of the absence of eligibility criteria for attendance at ED.

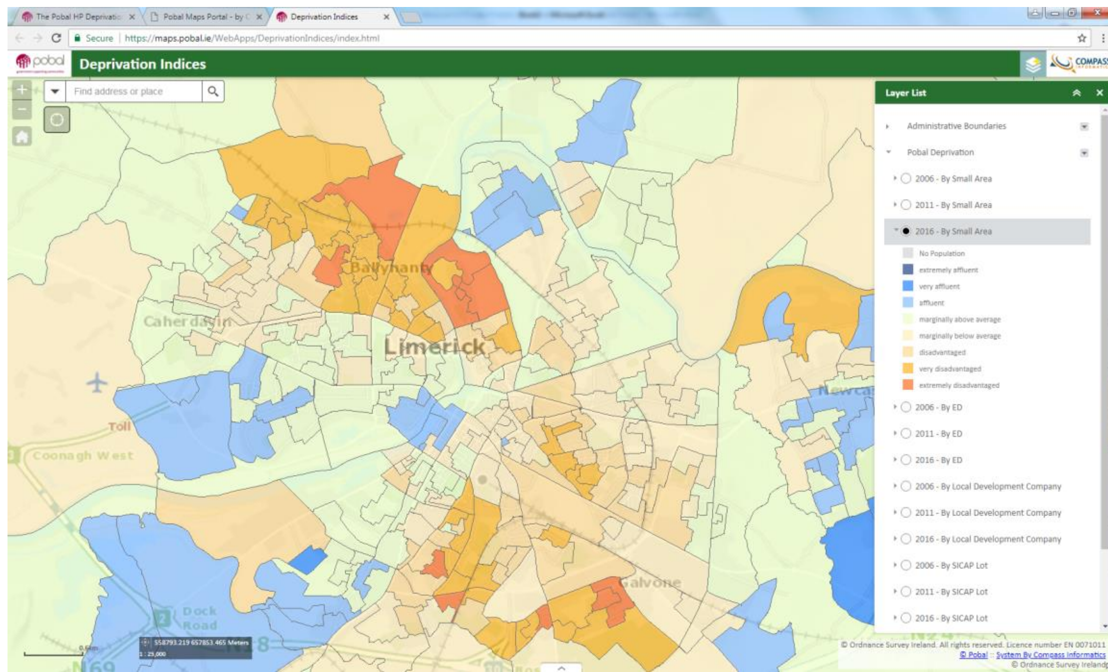
UL Hospital Group and St Johns, serve a population of 385,000 people. It has a unique demography in that Limerick City has the highest percentage of social housing within the city boundaries of all Irish cities, with a higher than average proportion of people in the socially deprived groups.

The 2016 Pobal HP Deprivation Index (Haase and Pratschke, 2016) indicates that Limerick City has over 40% of its population classed in the lower classes of disadvantaged, very disadvantaged or extremely disadvantaged (National Average is 22.5%). Conversely, UHL is surrounded by some of the wealthiest rural communities in County limerick. Limerick city is set to grow by 7.4% by 2030. By 2030 the Limerick City area is predicted to see an increase of 46.4% in the number of people aged 65+.

	Disadvantaged	Very Disadvantaged	Extremely Disadvantaged
Limerick City	19.8	12.7	7.6
Limerick County	14.1	4.6	1.3
Clare	15.4	5.3	1.3
North Tipperary	17.6	6.5	1.8
National Average	*15.0*	*5.8*	*1.7*

As illustrated in the table above, Limerick County has lower than average levels of deprivation. Clare is relatively average, and North Tipperary is slightly above National Deprivation levels. These levels of deprivation illustrate, that removal of private practice is unlikely to reduce the demand from more socially deprived and elderly patients whose eligibility to access public services will remain.

The map below sets out the deprivation index for Limerick City. Areas in Blue show those more affluent areas and the areas in orange/red show those areas very and extremely disadvantaged.



Elderly Population

The key to keeping elderly out of hospital is strong community health support, which is usually only available to those older people with Medical Cards. Insured elderly patients may initially gain access to private hospitals. However the nature of the chronic conditions and their social problems, often makes them unattractive to private hospitals who are reluctant to admit them. These patients are a significant financial drain on a private hospital's facilities.

There is much stronger community health support for elderly patients (over 75) who qualify for medical cards as they have greater access to public services in the community. it is often harder to discharge an elderly insured patients back into the community, as they are not eligible for medical cards and community health services. Uniform eligibility of all elderly patients is a prerequisite to facilitating early discharge of these patients back into the community. Removal of private practice from public hospitals should encourage this development.

ACCESS

The type of patients requiring planned access to model two and model four hospitals differ, and the impact of private practice removal will be different in these two different situations.

UHL – Model 4

Access to any inpatient beds in our only model four hospital – UHL is challenging, as it is has one of the busiest ED Departments in the State with 100 fewer beds than comparable hospitals with similar ED throughput. It is also the only model four hospital in the Group with no model 3 hospital to share the emergency service. This lack of beds impacts on our ability to work efficiently in our ED because of overcrowding.

This overcrowding also limits our ability to admit patients for planned surgery for cancer or complex time critical surgical conditions, or to admit the patient who is considered too high risk for an elective operation that would normally be done in the model two hospital. The removal of private practice from the public hospital is unlikely to alter this pressurized scenario without the creation of more inpatient beds in UHL.

If the access to private hospitals for the treatment of more complex diseases in the Limerick region – semi urgent and urgent - is not significantly improved then there will be no change in the level of demand for these services that currently exist. The mobile wealthier patient will often access these services outside Limerick, if they cannot gain quick access to UHL.

Achieving appropriate access for urgent assessment is possible when services are properly resourced, as has been seen with some of the cancer services at University Hospital Limerick. For example, the breast cancer service in UHL achieves all its key performance indicators for access, because there is proper funding. The consequence of this is that the demand by privately insured patients for dedicated private access has significantly fallen and removal of private practice within UHL would not impact on this service, provided the standard of care provided remains in line with

international standards. The cancer population are likely to continue to demand such a service

The private insurance population are likely to continue to use UHL for its emergencies, complex conditions and its cancer related care. This is reflected in the high percentage of private patients receiving cancer treatment in UHL which is approximately 50% of the caseload. Removal of private practice from the public hospital will not remove this population group, unless an alternative private facility is built. If this does not occur, and if standards of care in the public hospital are maintained or improved, then the private patient will merely access the current cancer facilities as a public patient.

Many patients with more critical medical conditions are in the elderly population. This represents approximately 30% of all those presenting to ED. The admission rate of these patients varies according to the time of the year, and the resources available in ED to arrange home care services and designated pathways of treatment outside the main hospital. Access to hospital of elderly patients is giving priority from the ED department, and removing private practice from the public hospital is unlikely to change this profile, as all elderly patients are better catered for in the public system because of the community support services that are not available to private patients who do not have a medical card.

The current practice of insurance companies encouraging their members not to claim their private insurance status when entering the hospital through the emergency department - because of poor accommodation – illustrates the view of the private sector towards provision of emergency care. Removal of private practice from the public hospital would bring full clarity to this issue, by leaving all the responsibility for the emergency service with the State. Clarity of funding models would then have to be resolved.

Access to Model 2 Hospitals (JENS) and Regional Orthopaedic Unit.

Day case, less complex routine surgical cases and elective orthopaedic surgery are dealt with in the Model 2 (Ennis and Nenagh) and 2S (St Johns) hospitals and the Regional Orthopaedic Unit in Croom respectively. Access to these hospitals is relatively

predictable and is rarely impacted upon by the overcrowding in the ED of UHL. The exception is when the bed crisis is escalated and "surge capacity" measures are put in place, which require that the day ward facilities of the model 2 hospitals and the inpatient surgical beds of St Johns and Croom are kept vacant to take emergency admissions. In the UL group, at least 30% of all elective admissions to the model 2 hospitals would be private.

Removal of the private patient from the inpatient waiting list of the model 2 hospitals in the UL group should free up a minimum of one third of all the beds for more elective procedures on public patients. It is likely that many of this current insured group would give up their private insurance if the admission advantage was removed.

This should lead to a shortening of waiting list times for public patients gaining access for elective procedures that are done as day cases or inpatients in these four hospitals. This assumes that the same level of funding will be provided after removal of the private income that currently funds at least one third of their activity. Currently our model of care for elective surgery has brought about a situation where UL hospital group has the shortest waiting lists for day case and elective inpatient surgery.

EQUITY

One of the main objectives of removing private practice from public hospitals is to achieve greater equity of access for all patients based on clinical need alone. Social status or ability to pay should not influence this.

The impact of removing private practice has been outlined above in terms of how it would improve access for routine elective surgery in the model 2 hospitals and the elective orthopaedic unit. This will only hold true, if one can guarantee the same level of care as currently exists when the public patient eventually gains access to the service. Resources will have to be maintained despite removal of the income support of private practice.

Currently all public patients must attend the outpatients in the hospital, whereas privately insured patients attend the consultant's private clinic. Timing of admission to hospital should be on the basis of clinical need, and time of booking on the common waiting list. Waiting times for public OPD for non-urgent cases can be in excess of two years, whereas any patients will see a consultant within weeks if they attend their private clinic. The question will be whether access to the public waiting list will be determined by having to attend the public outpatients, or whether private patients having " jumped the first queue" by seeing the consultant privately, then join the public queue for hospital admission more quickly. Irrespective of this issue alone, Equity of access to the public hospital would be improved if private practice is removed from the public hospital, as there will be less incentive to ensure preferential access of the patient who joined the hospital queue from the private consultation.

The most critical demand for hospital services is within the Model 4 hospital for the treatment of urgent, cancer and complex medical and surgical conditions. Removal of private practice from the public hospital will not change that demand in Limerick in the short to medium term, as there is no equivalent private hospital service to replace it.

A significant proportion of the population in the mid socio-economic group who live close to Limerick City are unlikely to maintain their health insurance if private practice is removed from public hospitals. This is because it will not confer any perceived advantage to them in terms of local access to their main hospital which they are likely to continue to use rather than travel outside the city. The net effect of this will be a population with a much lower level of private health insurance, and a greater sense of dependency on the public hospital system for the management of time critical complex conditions.

The proportion of patients with medical insurance in the Mid West region increased exponentially in the mid– noughties. At its peak, up to 60 per cent of females aged between 20 and 65 had private medical insurance (this related to Dell and other multinational employers providing medical insurance to all its employees). Clinical practice in Limerick within the hospitals was therefore dispensed to public and private patients "under the same roof".

The advantage of such a system was that the presence of the consultants “on site” was guaranteed, as all their public and private practice was within the one hospital. Criticism of this system is that private patients might be admitted in preference to public patients for equally important conditions, particularly when bed shortages exist. In such situations there is a financial incentive - for both the consultant and the hospital - to admit the income generating patient.

The change in the consultant contract in 2008 coincided with the economic crash, which saw the percentage of emergency insured patients presenting at UHL fall to under 25%. Equally, the stipulation in the 2008 consultant contract limits treatment of insured patients by a clinician to a maximum of 30% (20% for new consultants).

Enforcement of this contract has led to a larger proportion of consultants seeking a contract to enable them work in the new Bon Secours Private Hospital in order to supplement their public hospital salary. This removes the benefit of having the consultants on the same site continually, which is obviously less beneficial to the public patient.

It will have to be recognized, that there is a significant danger that the public hospitals will lose some of its best consultants to the private sector, unless the loss of potential earnings is compensated for and the resources within the public system – in terms of bed access, higher quality equipment, and stronger NCHD support is seen to occur.

Legislative and Legal Issues

Different payment arrangements for different income groups in the population generates a large amount of work for the hospitals, and an overall general entitlement for all patients should be provided.

Clarification of consultants obligations and entitlements under their contracts will also require review. In particular, if consultants ability to earn private income in the public hospital is withdrawn, then there will have to be a renegotiation of the 2008 contract.

Recruitment and Retention of Personnel

Currently, with the upturn in the economy, UL Hospital group generates 60 million Euro in income from all private/self-paying patients. All this income is incorporated into the hospital budget and is not directed in any specific way towards private practice in the hospital. Nor, does it impact on the pay and conditions of any employee group – Nurses, allied health etc - other than those hospital consultants who are paid separately by the insurance company for the work which generated the income for the hospital.

Consultants working in the UL group would generate significant personal income from the treatment of private patients. This data is available from the insurance companies in generic format for each specialty and region. Traditionally, Limerick would have had a reputation for generating good private practice for its consultants because of the medical insurance demographics outside Limerick city. This, inevitably, made it easier for the hospital to attract the best qualified Irish consultants to the hospital group, in competition with the other model 4 hospitals around the country. Strong consultant recruitment benefits all patients, but particularly the public patient who is totally dependent on the consultant service provided at the local hospital.

Consultant Recruitment

Currently in the UL hospital Group, approximately 10 % of the consultants have type C contracts which enable them to do private inpatient practice outside the public hospitals in the region. All the other consultant's private practice income is generated within the public hospital. The new proposed legislation to remove private practice completely from the public hospitals will completely change the income model of these consultants. The impact of the proposed changes will impact on different specialties in different ways.

Specialties, such as Emergency Medicine, Geriatrics, Acute Psychiatry, are not likely to be impacted by the private insurance changes proposed, except for the loss of income based on the percentage of

private patients admitted under these specialties in the emergency setting currently, which is relatively low. Specialties such as Paediatrics, and Acute Medicine would see a more significant change. There would have to be a significant compensation for this loss of income, and contract renegotiations would be necessary.

Surgical Specialties and other procedure based medical specialties will be the most impacted. The loss of earnings to consultants in these specialties is likely to be very significant in the Limerick region, as a surgeon with a minimum of 20 to 30 per cent private practice in one of the busiest hospitals in the country, is probably doubling his / her public salary with the private income generated within the hospital, and from the off-site private practice that will go with this practice model.

These procedure based specialties are where the longest waiting lists exist, and yet where it is hoped that the removal of private practice from the public hospital will improve throughput of public patients through the day ward setting, and the elective inpatient surgical units as outlined above. It would also hopefully ensure the processing all urgent and semi-urgent cases more efficiently. To process the volume of patients that one currently sees dealt with in the UL hospital group, many surgeons work well in excess of the required 39 hours per week. It is hard to see current consultants maintaining the same level of throughput in this new arrangement, unless overall salaries are maintained at the levels currently subsidized by the insured patient.

Many of these consultants are likely to seek renegotiation of contracts which will allow them access to private practice at another hospital. The degree to which this will be sought will be determined by the level of demand for private practice. In the short to medium term, this demand for elective procedures is likely to remain significant in the private sector. Hence Consultant retention in the surgical type specialties could prove to be a significant challenge and lead to an overall reduction in the standard of care being delivered to public patients.

Current and Future Funding Arrangements

Withdrawal of Private Insurance From Public hospitals

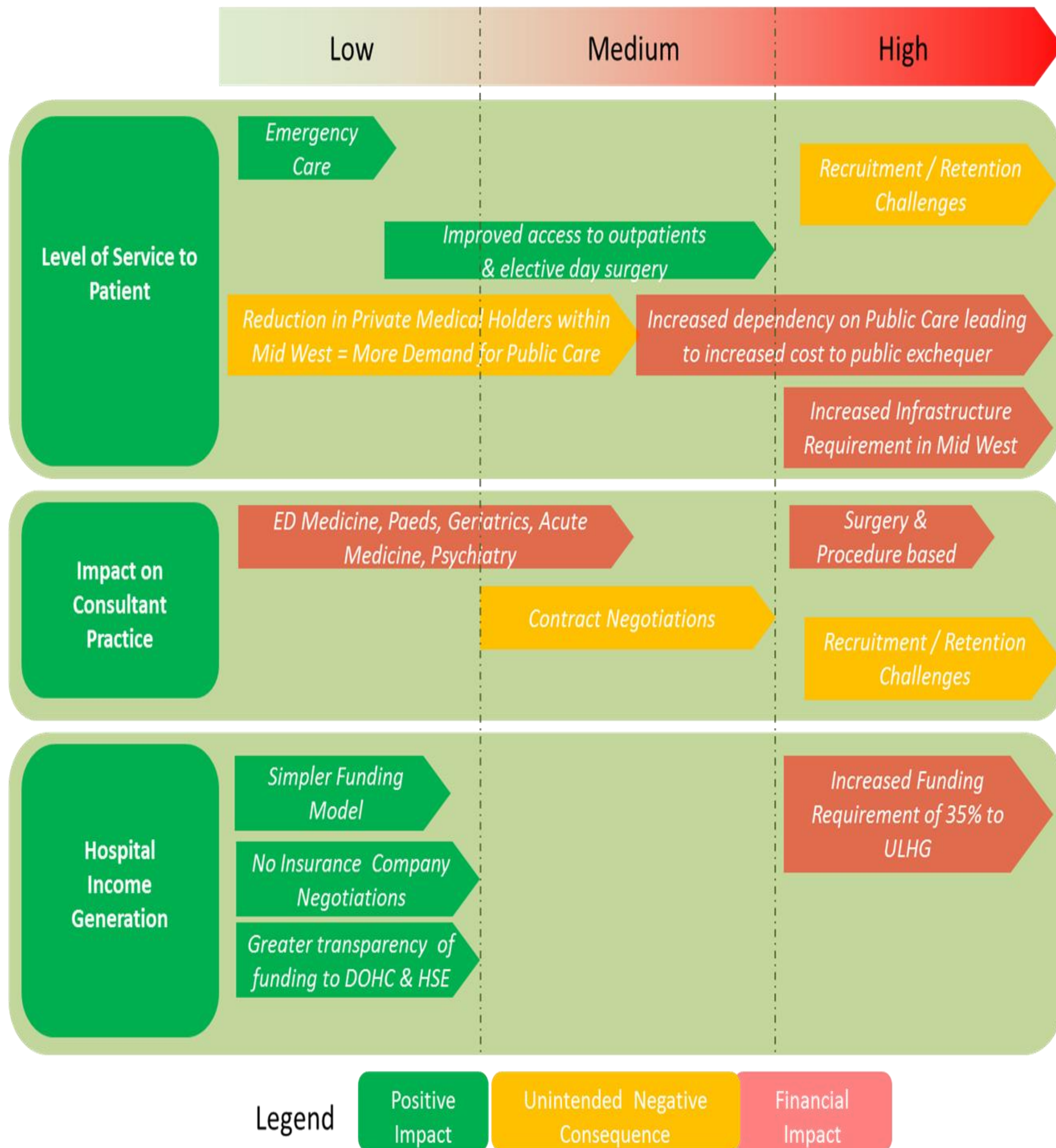
The effects of withdrawal of all private insurance income from the public hospitals in Limerick is likely to manifest itself in a number of ways related to income generation for the hospital

Income Generation to Hospital

Currently, UL Hospital Group is expected to generate income 60.2 million euro from approximately 30% of all patients attending the UL group. This represents approximately 16% of our yearly hospital budget of 379 million euro. The removal of private practice will mean a requirement by government to replace this income in order to maintain the current level of service. This will take the requirement off the hospital to negotiate with the insurance companies, and also mean they are less dependent on the consultants processing insurance claims efficiently. UL hospital group currently has 39.2 million euro in outstanding debt, due to delay in insurance claims being completed by consultants and ongoing disputes with insurance companies over claims.

From a financial management perspective, removal of private income as part of yearly budget, should lead to a more transparent model of hospital funding. It will also give the main paymaster – DOHC and HSE, total visibility of all income going into the hospital group, and also total control of how the hospital is funded. It is hard to see any negative aspect to this from a financial efficiency perspective, if one can be assured that the hospital continues to be funded to the level it previously enjoyed when the insurance companies were contributing to the funding up to 35% of all hospital activity.

A high level summary of the impacts of this change is set out in the figure below. It sets out those benefits to the patient and the hospital group in green, unintended consequences are set out in amber, and financial impacts are set out in red. These impacts are all rated low, medium or high.



Conclusion

The large dependency of the UL group on private insurance makes it vulnerable to underfunding by the state unless proper processes are put in place to guarantee the additional funding stream that will be required following removal of private practice