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Dr Donal De Buitléir
c/o Mr Ronan Toomey
Secretary to the Review Group examining Private Practice in Public Hospitals
Department of Health
Hawkins House
Hawkins Street
Dublin 2, D02 VW90

9th February 2018

Dear Dr De Buitléir,

Re: Reply from RCSI to the Review Group Examining Private Practice in Public Hospitals

Thank you for writing to RCSI as part of the consultation process your Review Group is undertaking. As we understand it you are acting on the request of the Minister to carry out an independent impact analysis of the separation of private practice from the public hospital system, with a view to identifying any adverse and unintended consequences that may arise for the public system in the separation. You asked that we provide such feedback under a number of themes and the following represents the views of the RCSI in that regard.

•Eligibility, access and equity

Eligibility

Currently all residents in Ireland are eligible to access our public hospital services, whether or not they are privately insured. This eligibility should not change. We believe that all residents should retain eligibility to obtain care in the Pubic Hospital System based on patient need and independent of how their care is funded.

The success of the National Cancer Control Programme, which provides cancer services based on the needs of patients and is accessible to all residents is an exemplar model which should exist for all services.

Access

Currently access to Public Hospitals in Ireland is in an unacceptable position. It is widely reported that there are now over 500,000 people waiting for an outpatient hospital appointment. There are over 81,000 people waiting for inpatient or day-case procedures. Commentators from our health service have recently said that 57% of those on in patient waiting lists wait less than 6 months and over 84% wait less than 12 months for their

procedures. Neither of these timelines is acceptable if we are to provide a reasonable standard of care to Irish patients.
The lack of bed capacity and the staffing needed to implement additional bed capacity in our hospitals is the main cause of the lack of access debacle.

The removal of private practice from public hospitals is unlikely to create any overall increase in bed capacity (when public and private beds are considered as the total resource available to patients). Many patients categorised as private in public hospitals have:

- emergency conditions (>70% of public hospital admissions)
- suffered significant trauma
- chronic conditions requiring timely repeated interventions (e.g. renal failure, diabetes, cardiac failure),
- extensive multi-morbidity requiring interdisciplinary treatment for other conditions (e.g. elective orthopaedic surgery),
- complex conditions (e.g. certain malignancies, vascular surgical conditions, neurosurgical conditions) requiring multidisciplinary care not available elsewhere

All of the above patients are most likely to be admitted to public hospitals regardless of categorisation based on the current service provision of the private hospital sector.

Some of the privately insured patients who access the public hospital system for care could be deferred to the private sector, depending on their needs. However, in the main, given the difficulty and delays in access it is highly likely that the majority of those who could be treated in private hospitals are already being treated in that sector.

Equity

RCSI supports equity of access to care for all patients based on clinical need irrespective of how their care is funded. The inequity created by the mix of private and public patients in our public hospital system arises out of how the way waiting lists are managed. Currently, hospital management are incentivised to increase private patient care activity to generate much needed supplemental income. This compounds inequity of access.

Access to private hospital care outside of public hospitals is currently not available in all parts of Ireland and patients may have to travel long distances from home to access service in private facilities (which may carry additional risks or costs) which are available much closer to their home in public hospitals.

•Legislative and legal issues

Currently, many Irish Consultants, in accordance with their contract, are permitted to treat private patients in public hospitals and charge those patients fees for this treatment in addition to the charges levied by the hospital. Changes to these arrangements may require contractual negotiations and/or changes to their remuneration or other contractual provisions. There may be other legislative and regulatory matters to be considered but this is not an area of expertise for RCSI.

•Recruitment and retention of personnel

The removal of private practice from public hospitals would lead to a reduction in the potential income of some hospital consultants. Ireland competes for surgical and medical personnel, and indeed all clinical personnel, in a global market. Irish doctors and surgeons are trained to the highest of standards and, in many other health systems they can earn significantly better salaries than the current level of consultant salaries in Ireland. Access to private practice in public hospitals may have helped to make consultant posts in Ireland more attractive.

The removal of private practice from public hospitals, with the likely impact on consultant remuneration may require renegotiation of the terms and conditions of existing consultants and make these posts less competitive for Irish and international specialists. In particular, this may impact on recruitment into smaller hospitals where recruitment and retention issues have already been identified and may impact on Ireland's ability to attract high calibre candidates into academic teaching hospital posts.

The removal of private practice income to the public hospitals would lead to a substantial reduction of income to already underfunded public hospitals which would exacerbate the difficult terms and conditions for our clinicians to deliver high quality clinical care. This already appears to be a factor that is adversely impacting on recruitment and retention of consultants in technical specialties such as surgery. A significant investment by the state would be required to both replace the lost income to the public hospitals system from private practice and ensure that the public hospital system is sufficiently funded to remain an attractive place for clinicians to work.

•Current and future funding arrangements

Public Hospitals in Ireland are highly dependent on the income from private patients to adequately fund the running of the hospitals. Removal of this income will require significant additional funding from the State just to maintain current levels of activity. In many cases, for reasons outlined above, the same patients will be treated but the income currently recovered from private insurers will no longer be recovered by the public hospital.

Private Health insurance is an effective manner by which patients can fund care that would otherwise require State funding. However, PHI is not affordable to all citizens and indeed the high levels of variance in the type of cover are not necessarily designed to meet the health needs of citizens.

As we have previously stated, the removal of private practice from the Public Hospital system will not directly increase overall capacity unless:

(1) there is a significant transfer of activity to the private sector (which is only reimbursed on the basis of activity) and,
(2) the loss of income from private health insurance is provided to the public hospitals as additional state funding without any significant increase in overall activity.

•Operational matters including specialist services

Certain services are generally not provided in the private hospital sector or provided on a very limited basis. Many complex conditions are considered economically unviable by the private sector to provide. Therefore this type of complex and expensive care will still remain the remit of the public hospital system requiring significant funding and terms and conditions of employment that would attract the clinicians to look after these patients.

From an operational matter, the removal of private practice would have little or no impact on the day to day working of the hospital, except that there will be a significant funding deficit on current levels.

•Practical approaches to removing private practice from public hospitals including timeframe and phasing

RCSI would recommend that a full and detailed analysis be conducted which would profile the volume, nature and location of private practice being carried out in the Public Hospital System and, in particular, the proportion of activity that would or could be transferred to the private sector.

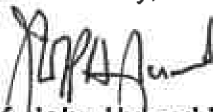
A full estimation of the private practice income to the public hospital system, regularly quoted as being €700m, should be conducted to determine the amount of additional public funding needed to just maintain current activity levels in hospitals if public patients (without private insurance) are not to be disadvantaged by the changes.

RCSI would recommend that a full analysis of the global nature of healthcare workforce recruitment and retention so that our public hospitals can recruit and retain our highly trained staff.

RCSI would ultimately ask the group to define the primary goal of such a health reform. If the goal is to generate additional public hospital capacity so that we can reduce waiting lists and improve access to care for all citizens, then the removal of private practice from public hospitals is unlikely to deliver such a goal unless substantial additional healthcare funding is supplied.

RCSI would be happy to engage further with your Review Group. Our involvement with the National Clinical Programme in Surgery and the National Office for Clinical Audit, both collaborations between RCSI and the HSE, has access to important clinical activity and quality data which could inform your analysis.

Yours sincerely,



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