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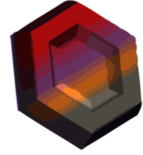

Secretary to the Expert Review Group examining Private Practice in Public Hospitals
c/o Room 424
Department of Health
Hawkins House
Hawkins Street
Dublin 2
D02 VW90

15th February 2018

Re: Consultation on Private Practice in Public Hospitals

Dear Secretary

Thank you for the opportunity to make a late submission on the consultation process referred to above.

The ideas in this submission require some detailed research, but I believe that it may be worth that analysis.

My submission is not long or overly detailed, is based on my experience as the CEO of a large teaching hospital, and on insight gained as Registrar and CEO of the Medical Council.

It is my view that private practice and public practice are so closely interwoven that it will be almost impossible to separate them in public hospitals.

However, in establishing arguments on this point, the level of data generally available on the usage of private and public beds is poor. So too is the level of financial data in respect of income from private patients. This is not to say that this data does not exist. The major health insurer in the country, VHI, which is owned by the Government has data on all activity relating to private practice in public hospital. While this data is commercially sensitive, it is clear that its usage in analytical term is essential for any decision-making process in respect of private practice in public hospitals.

While the system may have changed since I was a hospital CEO, I am aware that the past practice was to deduct the prospective income from private beds form a hospital's allocation at the beginning of each year. The hospital then had to charge for those beds to make up this deduction, but the highest percentage I can recall was close to 80%, thus leaving a 20% shortfall in income as a result of a variety of logistical reasons. If this practice continues to this day, it is mitigates against good management of private practice in public hospitals.

What is required is a far more transparent system of analysis indicating the level of access to services in public hospitals by (i) private and (ii) public patients.

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Data must be published on the level of intra-consultant referrals for both private and public.

Any plan to completely separate public and private would not, in my opinion, be a viable option. It would mean that either private hospitals limit their cases to 'elective only' with a low risk of complications, thus putting pressure on the already busy public system or, alternatively, private hospitals would manage a more complex case-mix that would require access to expensive intensive-care or high-dependency beds on their own premises. If these beds were to be unavailable, the private hospitals would have to pay for the treatment of acute cases in intensive-care units in a public hospital at a commercial rate, which would be an expensive option. This would also necessitate transfer of patients from one system to the other.

On the plus side, if private beds are removed from public hospitals, access for public patients should improve and the incentive to purchase private health insurance would lessen.

On the minus side, private costs will increase as private hospital are forced to purchase high cost care from the public system, leading to a rise in subscription rates for a decreasing number of subscribers, and impact on consultants.

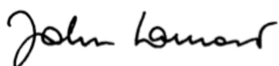
The answer may lie in passing on the charge for private patients' in public hospital beds to the consultant, rather than penalising the hospital for less than optimal use of designated private beds. By subjecting the consultant to a levy, on a scaled basis, and introducing a quota for the number of bed days they can use for their private patients, either individually, by specialty, or in total, the onus would then be on consultants to control their use of a limited number of beds/bed days (which is possible), and not on the hospital management (which is not possible). This measure would assist consultants in planning their public workload alongside their private practice.

Consultants would have to negotiate among themselves as to their access. Hopefully, all patients would continue to be treated on the basis of need and no one should suffer due to lack of access.

The resistance that would probably follow from consultants who may lose some access to private practice would be a matter for negotiation.

Thank you for the opportunity to make this brief submission.

Kind regards.



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