Submission to the Independent Review of Private Practice in Public Hospitals.

8 February 2018

The Opportunity

The Private Hospitals Association (PHA) welcomes the Sláintecare proposals to remove private practice from public hospitals. Private hospitals already play a substantial role in health care in Ireland including care of 400,000 patients annually in a very wide range of specialities. While the likely increased demand for private hospital care arising from this policy change would be significant, the membership of the Association is confident that it can respond to this new reality with additional investment as necessary in both facilities and personnel to be able to treat additional patient numbers. This response would match what we anticipate would be a planned and phased implementation of the policy change.

Ireland's growing and ageing population will require a steady increase in hospital services in the coming years. Demand already exceeds supply as evidenced by the twin challenges of excessively long waiting lists and over-stretched emergency department services. While a system-wide response is ultimately required to comprehensively address this issue, one immediate means to boost bed numbers and provide greater access to treatment is for Government to change tack and to draw on the private sector's ability to quickly deliver significant additional capacity.

The recommendation by the Joint Oireachtas Committee on the Future of Healthcare (Sláintecare Report) has the potential to be a significant policy lever in this regard and should be acted upon immediately. A clear signal by Government to the private hospital sector that they should invest now to serve increasing numbers of insured patients over the coming years would have an immediate impact and result in the provision of hundreds of additional acute hospital beds and new investment in operating theatres, emergency department facilities, cardiac and cancer services. This would happen quickly and would start to immediately relieve pressure on over-stretched public hospitals while allowing the public system to proceed with the public capital investments that are still also necessary, albeit with inevitably longer planning cycles.

Essential elements of the phasing out policy.

Before responding to the specific issues where the expert group has invited comment, the Association would wish to underline the following core considerations of the strategy:

1. Clear, consistent, policy.

An unambiguous public policy commitment to implementation of the Sláintecare recommendation on phasing out private care in public hospitals will be essential to encourage additional private sector investment. The broad political consensus demonstrated by the Dáil Committee in developing the Sláintecare recommendations will need to be carried through into the implementation phase. Political parties will need to commit themselves to the implementation of this policy over a ten-year period to instil investor confidence. Otherwise uncertainty will be priced into the costs of investment, delaying decision making, increasing prices and borrowing costs and diluting the benefit of the overall intended strategy.

2. A private patients' capacity review including of the limits on insured beds.

As part of the work of the expert group the PHA urges the preparation of a capacity review of demand for private health care facilities in a scenario where the private patient is no longer being treated in a public hospital. This review should mirror the recently published Department of Health capacity review of the public system. As a priority, it should also address the issue whereby the number of beds available in the private system is constrained by the availability of coverage by health insurers. In recent years there have been only very limited approvals by health insurers for additional capacity despite the changing demographic situation. The expert group should recommend the sale of the VHI as it no longer needs to be owned by the State, in turn bringing new competitive forces into the health insurance market. By new forces entering the health insurance market, it will help to create the dynamic for a lifting of the current constraints placed on private hospital bed supply. Given the Central Bank's role in the regulation of health insurers, the State no longer needs to occupy the role of principal shareholder of the largest player in the Irish health insurance market.

Regulatory measures may also be required to ensure that supply of beds of other services in private hospitals is not inappropriately constrained by health insurers.

3. Parity of esteem for private providers.

It is current Government policy that only public hospitals are eligible to be Designated Cancer Centres. While a range of clinical considerations should apply in the identification of a facility as an approved cancer centre, there is no good policy reason why State ownership should be one of the relevant considerations. This is also relevant in the context of the National Review of Specialist Cardiac Services which is currently underway.

4. Maintaining the integrity of the health insurance market

Customers of health insurers contribute in excess of €2Bn in health insurance premiums each year in Ireland. These funds represent a very sizeable additional contribution to the spend on acute healthcare in the country. In framing its recommendations the Expert Group should ensure that confidence in, and demand for, voluntary health insurance is maintained and increased as a result of the policy and legislative changes. Health insurance contributions

should be protected by legislation and they should not be accessible as an easy source of additional revenue to top up funding of the public health system. This principle will be particularly important in an era where private care has been separated from public hospitals.

PHA comment on specific subjects identified by the Expert Group:

i. Eligibility, Access and Equity

Eligibility for public health care is a right of all citizens irrespective of their health insurance status or their ability to pay.

Access should be based purely on clinical need - no patient in the public system should be able to secure priority in seeing a doctor or receiving treatment on the basis of payment - either directly or through an insurance fund.

Similarly, no insured patient should be placed at any disadvantage to a patient without insurance when seeking treatment in a public hospital. Patients should not be required to disclose their insurance status when seeking treatment, and data on their insurance status should not be held by a hospital from one visit to the next.

The current arrangement whereby insured patients are charged much higher fees for treatment in public hospitals than non-insured patients should be terminated immediately.

ii. Legislative and legal issues

The most effective way to ensure separation on a permanent basis would be to underpin the goals of the Sláintecare Report with legislation to ensure public hospitals are statutorily barred from treating patients on a fee basis. While this should not hold up the decision to proceed, such legislation could be introduced later in the process to copper-fasten reform.

The largest legal challenge attached to this policy change is the nature of any future consultant contract and the manner in which it would underpin or undermine the policy of separation. This needs to be addressed in legislation.

iii. Recruitment and retention of personnel

Consultants working in the public system should fulfil their contractual obligations by exclusively treating public patients but without being precluded from additionally working in the private system if they so wish.

Reform of the consultants' contract should include flexible models permitting public hospitals to contract consultants to work to set hours as appropriate and required. This will enable the hospitals to achieve best value for money and the consultants to work in off-site locations as they desire.

This new approach to a consultants' contract will also assist in attracting suitably qualified consultants to come into or more likely to return to Ireland, a very small island in terms of healthcare, giving returnees a range of options in terms of private/public mix in terms of careers and earnings.

iv. Current and future funding arrangements

The Minister is on record about the gap in funding for public hospitals that will emerge if insured patient revenue is no longer available to the HSE. The Government will need to acknowledge that this funding gap will have to be backfilled by additional exchequer expenditure as it is not likely that costs could simply be taken out of the system. This ought to be viewed as a major opportunity rather than a threat. The PHA would encourage the expert group to challenge hospitals and hospital groups to set out how they would optimise the use of the personnel and other resources that would become available if their patient numbers were reduced due to policy change. It is regrettable that the terms of reference of the De Buitléir group did not include the task of assessing the opportunity for ramping up public care as a result of this policy.

v. Operational matters including specialist services

The PHA has consistently argued that the separation process should be conducted on a phased basis, beginning with elective admissions.

- **Elective admissions**

The majority of elective treatment provided to insured patients in public hospitals could be phased out over the next three years – with an immediate positive impact on public waiting lists for procedures.

- **ED admissions**

Many insured patients currently end up being treated in public hospitals simply because they were admitted through emergency departments. Collaborative planning initiatives should commence immediately in each hospital group area and with relevant stakeholders to explore how insured patients can be diverted to private hospitals in their area after their initial assessment.

While certain patients will not be suitable for transfer to another hospital, others who elect to be treated privately and who are clinically assessed as suitable for movement and treatment in another hospital should be facilitated. This approach will require careful joint planning by those responsible for clinical governance in both hospitals and could provide considerable assistance in relieving pressure on public hospital EDs and wards.

As noted earlier, an unambiguous commitment by Government to a policy phasing out private care in public hospitals, will trigger important changes in the operation of private

hospitals and to accommodate additional patients – particularly ED patients rather than elective admission.

Over time, PHA members will invest as necessary to accommodate all those patients currently receiving private care post ED admission who elect to be treated privately and who transfer to a private hospital. Over time also, the existing Emergency Department services within the private system will expand in terms of range and opening hours in response to increasing demand and other Emergency Departments may open.

Appropriate arrangements will be necessary in respect of a range of related issues including clinical indemnity and the role of the national ambulance service.

- **Maternity care**

Maternity care requires a specific approach and longer lead time before the private care currently provided in Irish maternity hospitals could be offered in one or more private settings. It is recommended that the Expert Group ring fence this area of care, acknowledging that a planning time frame of greater than 5 years will be required to develop suitable services in the private sector

- **Other specialities such as organ transplant**

Other key specialties currently largely or exclusively offered in a subset of specialist public hospitals such as transplant, stroke care etc need to be specifically reviewed too, like maternity services, by the Expert Group.

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

A special transition steering group should be established to oversee the implementation phase of this seminal change in health policy, and the PHA would be happy to participate in such a grouping, as it also would in the Emergency Task Force for Winter Planning if invited. The move of private practice to private hospitals could be introduced on a pilot basis within a specified Hospital Group area in order to ensure a smooth transition and to allow the system to learn and adapt from the initial rollout.

The Association would welcome an opportunity to meet with the Expert group to further tease out the challenges and opportunities inherent in this policy proposal as the group progresses its work.

About the Private Hospitals Association (PHA)

The Private Hospitals Association represents 19 private hospitals across Ireland that treat over 400,000 patients annually, have a cumulative turnover of approximately €1Bn per annum and employ over 8,000 fulltime healthcare staff. Further information about the association can be found at www.privatehospitals.ie