

Report of the Independent Review Group established to examine Private Activity in Public Hospitals

February 2019

The lower half of the page features an abstract graphic design composed of several overlapping, semi-transparent geometric shapes in various shades of purple and maroon. The shapes are arranged in a way that creates a sense of depth and movement, with some shapes appearing to be layered on top of others. The overall effect is a modern, minimalist aesthetic that complements the formal title above.

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Preface – Message from the Chairperson

Removing private care from public hospitals will be complex, will take time and will come at a financial cost.

The Review Group examined why private activity happens in our public hospitals, the nature and scale of such activity and gave detailed consideration to the many interlocking and complex matters which will have to be addressed in order to change our public hospital system to exclusively treating public patients. The Review Group arrived at a small number of practical recommendations. While some difficult decisions will have to be made to implement the recommendations in this report, the Review Group believes that private care can be removed from our public hospitals over the lifetime of the Sláintecare programme of reform. However, it is clear that the recommendations in this report alone will not be sufficient. Matters such as the expansion of hospital capacity, reducing waiting times and the reconfiguration of health services through better primary care services and access to diagnostics will also be prerequisites for success.

I would like to thank the members of the Review Group - Alan Ahearne, Ann Doherty, Nuala Hunt and Barry O'Brien - for the expert contribution they made to our deliberations and to this report. Their dedication to this review and willingness to share their knowledge and expertise made an immeasurable contribution to the report.

The contribution of the secretariat, in terms both of the quality and volume of work has been outstanding. The Secretary, Ronan Toomey, assisted by Evette Wade and Christopher Kennefick drafted our report and organised our work most efficiently.

Removing private activity from public hospitals was identified in the Sláintecare Report by the Oireachtas Committee on the Future of Healthcare as an important step towards achieving a single tier, universal system of health care and which would address much of the inherent unfairness in our public hospital system. The recommendations which have been made in this report identify a clear path, over the lifetime of Sláintecare, through which private activity can be removed from our public hospitals, allowing our public hospitals to exclusively treat public patients.

Donal de Buitléir

Chair of the Independent Review Group

Executive Summary

The 2017 Sláintecare Report proposed the phased elimination of private care from public acute hospitals, leading to an expansion of the public system's ability to provide public care. The Oireachtas Committee on the Future of Healthcare acknowledged that removing private care from public hospitals would be complex and it proposed an independent impact analysis of the proposal to identify any adverse and unintended consequences that may arise for the public system.

Our task is to analyse this proposal to identify the implications. As part of our work, the Review Group undertook a consultation process, which involved publicly inviting submissions from interested parties, meeting a number of stakeholders and visits to two hospital sites. We conducted a detailed analysis, examining the scale and nature of activity in our hospital system and matters relating to the people who deliver our health services. This included an analysis by the ESRI of the nature, level and role of private practice in public hospitals. Additionally, work was done by the Department of Health's actuarial consultants in relation to the impacts on private health insurance.

We also investigated the international experience, including inviting the WHO-hosted European Observatory on Health Systems and Policies to present an evidence briefing and requesting the OECD to conduct a desktop exercise looking at how dual public and private practice is organised and regulated in a number of OECD countries and the opportunities and challenges these countries are facing.

The Review Group believes that the long term removal of private activity from public hospitals can be achieved over a transition period. This could commence through immediate action on the consultant contract in parallel with capacity enhancements and increased funding for the expected increase in public activity.

This report presents our findings.

Vision

The Sláintecare vision is to provide an integrated health service which delivers care based on the needs of people and not ability to pay. More care should be provided at home or close to home in community rather than acute settings. People should be able to access care when they need it in a timely manner. Those who use public hospitals should not be disadvantaged by lack of financial resources and removing private activity from public hospitals would be a significant step towards achieving that vision.

Inequity

The present system is widely perceived to be unfair in that those with greater means may be able to be treated more quickly in public hospitals than those who have to rely entirely on the public system. Their treatment may also be more likely to be consultant-delivered. It is difficult to quantify the extent to which private patients may access treatment more quickly in public hospitals. We received anecdotal evidence that this is the case at least in some instances and insurers told us that it is one of the main reasons why people choose to buy private health insurance. Lack of timely public diagnostic facilities causes delay for public patients. Other elements of Sláintecare, including investment in community-based diagnostics facilities, new models of care and significant improvements in community and primary care services will need to be implemented to fully address these issues.

Capacity

Public hospitals do not have sufficient capacity to treat all patients in a timely manner. This leads to unacceptably long waiting lists. The need for increased capacity has been recognised in the 2018 Health Service Capacity Review commissioned by the Department of Health.

Underlying the Sláintecare Report is a belief that removing private patients from public hospitals will lead to an increase in capacity for public patients. There will be an increase in public capacity as private activity is removed as long as the necessary additional consultant and financial resources are provided. However, it is likely that a significant number of what would be private patients under the current system would become public patients under the new system for reasons such as:

- Some procedures are not available in private hospitals and are unlikely to be provided there in the future;
- Private patients attending emergency departments will remain for treatment in a public hospital as no alternative emergency departments exist

Consultants

The successful removal of private activity from public hospitals depends critically on the contractual arrangements with hospital consultants.

To begin the removal of private activity from public hospitals, it is imperative that new consultants are given contracts that allow only public activity in public hospitals. To ensure that such posts are attractive, it will be necessary to review the remuneration package so that it is at a level sufficient to attract people with the appropriate skills and experience. A more flexible approach to remuneration such as applies in the third-level education sector may be necessary to fill particular highly specialised posts.

Of existing consultants, the vast majority - about 2,500 consultants - have contractual rights to treat private patients in public hospitals. It will be necessary to enter into negotiations on the proposed "Sláintecare Consultant Contract". Some consultants with existing private practice rights in their contracts may opt to retain these for some time in the future.

This does not mean that significant progress cannot be made. The Hanly Report (DOHC, 2003)¹ recommended that 3,600 consultants be employed by 2013 and we are still some way behind that number. As a result, there is scope to appoint a significant number of consultants, all of whom should be contracted under the new Sláintecare Consultant Contract we outline in this report.

Some argued in submissions to the public consultation process that the proposal to remove private activity from public hospitals would make it very difficult to attract and retain consultants. They pointed to the difficulty in recruiting consultants to some positions at present.

The difficulty in recruiting consultants is partly due to the inferior terms under which new posts are offered following the pay reductions introduced on foot of the financial crisis. It will be important that these pay reductions are fully reversed as soon as possible. The fundamental economic point is that allowing private practice is a very inefficient means of increasing the attractiveness of posts because the potential earnings from private practice vary significantly among different specialities.

However, financial rewards are not the only reason why recruitment is difficult. Working conditions also need to be addressed, with the capacity of public hospitals under serious strain from the service demands placed on them while the reality must be faced that positions in some smaller hospitals will never be attractive. Many posts are difficult to fill because potential applicants may consider they face reputational risk and limited career progression opportunities for accepting such posts.

The effectiveness of the monitoring arrangements for the current consultant contract has attracted media and public attention. Until recently, the HSE relied on aggregated national data and a declaration of compliance with the contract by individual consultants to provide the necessary assurance that the restrictions on the level of private practice were being observed. Clearly, this approach has been inadequate. Following the settlement in summer 2018 of a High Court case taken by a number of consultants regarding pay reductions imposed as a result of the financial crisis, a new system of monitoring compliance has been introduced. It is too early to judge the results which will follow from this new system. In our view, it is important that a robust system is in place to ensure compliance with the provisions of the contract.

1 Department of Health and Children, 2003, Report of the National Task Force on Medical Staffing see <https://health.gov.ie/blog/publications/report-of-the-national-task-force-on-medical-staffing-hanly-report-2/>

While the Review Group considers it preferable that consultants employed in the public health service are 100% dedicated to their public work, the question arises as to whether consultants under the new contract should be free to work offsite when their public commitments have been fulfilled. While we have no objection to this, in principle, any such arrangements should be subject to the prior approval of hospital management, should only occur when there is no potential risk to patients and should prioritise the interests of public patients in public hospitals.

Impact on Health Insurance Market

The cost of private health insurance will rise under the present system due to the ageing of the population.

The question arises as to what additional impact on the insurance market will flow from the implementation of the proposal to remove private practice from public hospitals. This is difficult to predict because health insurance is a complex market and introducing significant change can bring numerous variables into play, the interaction of which is challenging to analyse with certainty. In the short term, the progressive removal of income from statutory charges on those who declare as private patients in public hospitals should lead to a reduction in the cost of private health insurance below what it otherwise would be.

In the longer-term, it is likely that the number of people choosing to buy insurance will fall as the proposal is implemented as there will be less opportunity to avail of private treatment in public hospitals. Insured people who will be most directly affected by the change include those who primarily receive their private treatments and benefits in public hospitals (estimated to be about 800,000 people, or 40% of the current market). These are the people most likely to reconsider the need for health insurance, especially if public hospitals are seen to be delivering timely, quality healthcare.

Any fall in the number of people insured is likely to be more pronounced among the younger age cohorts, which could result in increases in the average cost of health insurance for those retaining cover. A regional effect can also be anticipated, with parts of the country in which there are few or no private hospitals seeing greater numbers of people choosing not to renew their cover. Ultimately, should a very large number of people choose to discontinue their insurance cover, including because of enhanced public services, there could be a change in the nature of insurance to a more supplementary model. In the longer term, a public hospital service that is fit for purpose and has the ability to respond to the public demand for services should lessen the need for most people to have insurance.

Impact on Exchequer Finances

Most of the costs of implementing the proposal arise under two headings.

The first is the removal of income from statutory charges for those who opt for private treatment in a public hospital. The Oireachtas Committee on the Future of Healthcare recommended that this be done over a period of 5 years at a cost of €626 million per annum (although current income from private activity is estimated at €524 million for 2018). It should be noted that because private activity in public hospitals would not cease overnight, this amount will initially be quite low but will increase over time as more patients are treated publicly. This increased cost will be partly offset by the lower cost of tax relief on medical insurance premiums as the cost of premiums will fall as fewer people access private services in public hospitals with a consequent drop in payments for services by insurers. In addition, increased numbers of patients will now be liable for public charges.

The second relates to increases in the pay of consultants (both newly appointed and those who opt to change to the new public only contract) which may be necessary to ensure these posts are attractive.

We have identified a number of options to meet these costs.

International comparisons

The evidence briefing presented by the European Observatory on Health Systems and Policies and the report presented by the OECD confirm the role that private practice plays in many other countries. It is clear that other countries experience many of the same issues relating to private practice that occur in Ireland – private practice allows for patient choice, plays a role in recruitment and retention of doctors and is used as an income source for hospitals. We were also told of similar problems with the monitoring and regulation of private practice and that removing private activity from public hospitals on its own would not solve the many problems of the Irish health service including our long waiting times. However, the OECD concluded that removing private activity from public hospitals would eliminate the unequal treatment of public and private patients in public hospitals.

Implementation

To fully implement the removal of private practice from public hospitals will take a number of years but a start can be made immediately. The sequencing of the removal of private activity from public hospitals should be very carefully considered within that context but an immediate priority should be to begin the process by taking a number of important and early steps towards the removal.

The Government should send a clear signal that, at some future date, private activity will no longer be permitted in public hospitals. This intention should be underpinned by a new legislative framework that ensures that public resources are used only for purposes of providing public services in our public hospitals.

A necessary early step is to begin recruiting consultants to work in public hospitals who will exclusively treat public patients in these hospitals. There is also scope to significantly increase the number of consultants to move towards a consultant-provided as opposed to a consultant-led service, as envisaged by the Hanly Report.

It will be important to make significant progress towards the vision in the Sláintecare Implementation Strategy of a reorientation of the health service to a more integrated system, providing care on the basis of need, and not ability to pay and where the vast majority of care takes place in primary and community care settings. For example, there should be an extension of entitlement to, and the range of, primary care services before any consideration is given to reduction of hospital charges. This is to avoid providing incentives for people to seek treatment in hospital when they should be cared for in a more appropriate setting.

Recommendations

The Review Group makes a number of recommendations which are summarised as follows:

- **Introduce legislation to ensure that public hospitals are exclusively used for the treatment of public patients from the conclusion of the ten-year Sláintecare implementation period.**
- **All new consultant appointments should be to a Sláintecare Consultant Contract, which allows only public activity in public hospitals.**
- **Restore pay to pre-October 2012 pay levels for all existing Type A contracts and new entrant Sláintecare Consultant Contracts**
- **Consultants holding 2008 (or earlier) contracts under which the consultant conducts private activity on a public hospital site should be offered a “contract change payment” to move to the new Sláintecare Consultant Contract.**
- **Introduce a scheme to allow a special derogation from pay caps to address recruitment to highly specialised posts.**
- **The Department of Health should ensure that HIQA’s quality and safety regulatory functions are extended to all healthcare settings.**
- **Comprehensive data should be collected on the nature and scale of activity in the private hospital system equivalent to those collected in the public system**
- **Implement the agreed monitoring and reporting system to robustly monitor and enforce the existing consultant contract.**

1. Introduction

Sláintecare, a ten year strategy for health care and health policy in Ireland

On 1 June 2016, the Dáil agreed to establish a Special Committee - the All-Party Oireachtas Committee on the Future of Healthcare - to achieve cross-party consensus on a single long-term vision for health care and the direction of health policy in Ireland, and to make recommendations to the Oireachtas in that regard.

On 30 May 2017, the Committee published its final report, the Sláintecare Report, with proposals for a ten-year strategy for health care and health policy in Ireland². The publication of the Sláintecare Report is the first time that cross-party consensus has been reached on a new model of healthcare to serve the Irish people. The Committee's vision is for a universal single-tier health and social care system where everyone has equitable access to services based on need and not ability to pay. Over time, everyone will be entitled to a comprehensive range of primary, acute and social care services at no cost or reduced cost.

The Sláintecare report describes the current inherent unfairness in the health system when it comes to accessing care. It points to the issue of private practice in public hospitals as being one of the matters which requires attention to address this inequity in access to care.

One of the Committee's specific aims was to shift care out of hospitals and into the primary and community setting which will, in turn, help address the challenge of access to acute hospital services. Other measures were also identified including waiting time guarantees for hospital care and expanded hospital capacity.

In particular, the Committee recommended the phased elimination of private care from public hospitals and that everyone would be entitled to access public care in public hospitals. Those who have private health insurance would still be able to purchase care from private healthcare providers.

In recognition of the complexity of separating private activity from the public hospital system, the Committee recommended that an independent impact analysis of the separation of private practice from the public system would be conducted in order to identify any adverse and unintended consequences on the public system.

² Sláintecare Report, Houses of the Oireachtas Committee on the Future of Healthcare, https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf

Establishment of a review group

Arising from the recommendation in Sláintecare to conduct an independent impact analysis of the separation of private practice from the public system, the Minister for Health, Simon Harris T.D., established an Independent Review Group to examine the removal of private practice from public acute hospitals. The Minister issued the following Terms of Reference:

The Review Group will examine and enquire into the effects of the removal of private activity from public hospitals and will specifically examine potential benefits and potential adverse consequences, including any unintended consequences that may arise, in the removal.

In particular the group will examine and consider:

- *the existing nature, level and role of private practice in public hospitals;*
- *the negative and positive aspects of private practice in public hospitals, including as regards access to healthcare, equity and the operation of public hospitals;*
- *what practical approaches might be taken to the removal of private practice from public hospitals, including timeframe and phasing;*
- *possible impacts, both direct and indirect, immediate and over time, of removing private practice from public hospitals, including but not limited to impacts on: access; hospital activity (including specialist services); funding; recruitment and retention of personnel; and any legal or legislative issues that might arise*

and to make such recommendations to the Minister as the Group may see fit within a period of nine months of the commencement of the Group's work.

The Minister appointed the following as members of the Independent Review Group:

- Dr Donal de Buitléir, Chairman of the Low Pay Commission; formerly HSE Board member (Chair)
- Professor Alan Ahearne, Professor of Economics, NUIG and Central Bank Board member
- Ms. Ann Doherty, Chief Executive Cork City Council; former HSE National Director
- Ms. Nuala Hunt, FCA, former Governor NMH and former director of HSE
- Mr. Barry O'Brien, Director of Human Resources UCC; former HSE National Director HR.

Support for the Review Group was provided by officials from the Department of Health.

The work of the Review Group

The Review Group met for the first time on 14 December 2017 and met on 15 occasions throughout 2018. The Group also visited Cork University Hospital and the Mater Hospital, engaged with the WHO's European Observatory on Health Systems and Policies and the Organisation for Economic Cooperation and Development (OECD), and with a range of different national and local stakeholders directly.

The Review Group was particularly mindful of the request to identify any adverse and unintended consequences that may arise for the public system in their development of recommendations about the practical approaches that can be taken to remove private practice from public hospitals, the impacts that this removal will have, what timeframe might apply and how to phase the removal over time. Because private activity has been such a long-standing and prominent part of the public health service and the health service is so reliant on private activity, any proposal to remove private activity will not be a straightforward proposition. Indeed, successful removal of private activity from public hospitals must be seen within the wider context of the full package of measures in the Sláintecare Implementation Strategy published by the Department of Health in August 2018³. In particular, the Review Group believes that carefully sequenced and fundamental improvements in primary and community care should help to minimise demand on acute hospital services.

As will be seen from the conclusions in this report, the Department of Health will need to give consideration to the timing and sequencing of a number of the recommendations. The Review Group also believes that a number of the recommendations in this report can be implemented regardless of the timing of complete removal of private practice from public hospitals and would, in and of themselves, address some of the fundamental problems relating to access and equity in the health service.

Public consultation

The Review Group agreed that it would be helpful to hear the views of the public and interested parties as part of a consultation process, the details of which are reported in section 2.

Commissioned work to support the Independent Review Group

As part of the ESRI Research Programme in Healthcare Reform, funded by the Department of Health, the ESRI was asked to conduct an analysis of the nature, level and the role of private practice in public hospitals for 2015 to help inform the deliberations of the Independent Review Group. The report, which has been published as an ESRI Working Paper and is available on the ESRI website⁴ examines the extent

3 Department of Health, 2018, Sláintecare Implementation Strategy, see <https://health.gov.ie/blog/publications/slaintecare-implementation-strategy/>

4 Keegan C, Brick A, Wren MA (2018), An examination of activity in public and private hospitals in Ireland, 2015, ESRI Working Paper No. 601, ESRI, Dublin, 2018.

to which activity in public hospitals is privately financed, the level and nature of privately financed activity across the hospital system and shares of activity in public and private hospitals.

In an international context, it is not unusual to have a mixture of public and private healthcare systems. However, in Ireland it is the case that the public and private health systems operate with a large degree of overlap, particularly in our public hospitals. The Department of Health Secretariat on behalf of the Review Group engaged with international experts to develop a greater understanding of the international context and to explore options that might be applicable in Ireland.

The WHO's European Observatory on Health Systems and Policies delivered an evidence briefing on private practice in public hospitals that greatly assisted the work of the Review Group in developing this Report. A summary of the briefing is included in Appendix 7.

The OECD Secretariat (Health Division) conducted a specific desk top study to assist the Review Group, providing valuable international comparative analysis of country experience and empirical evidence on private practice in public hospitals. In particular, the OECD reported on comparable health systems where such an intertwining of private healthcare and the public hospital system occurs, what policy or reform directions those other countries may be taking, what evidence exists internationally on private practice in public hospitals and what possible strategies other countries have adopted to improve recruitment and retention for doctors in hospitals and other countries experiences of oversight and management of consultants. The report produced by the OECD is available on the Department of Health website.

2. Consultation

Introduction

In this chapter we describe the main themes raised in the submissions received during the public consultation process.

Background

A public consultation advertisement in the national newspapers on 18 December 2017, on the Department of Health's website and on social media, combined with direct approaches to identified key stakeholders, prompted a total of 47 responses from a range of organisations and individuals.

The advertisement asked to hear views about the current arrangements in relation to private practice in public acute hospitals; the future direction that such arrangements should take; and suggestions for transitional arrangements to give effect to the future direction. In particular, the Review Group asked to hear views in relation to the following:

- Eligibility, access and equity
- Current and future funding arrangements
- Legislative and legal issues
- Operational matters including specialist services
- Recruitment and retention of personnel; and
- Practical approaches to removing private practice from public hospitals including timeframe and phasing.

A list of the organisations and individuals who made submissions is included in Appendix 2 and the submissions in full are available on the Department of Health website at <https://health.gov.ie/blog/publications/independent-review-group-private-practice-in-public-hospitals/>.

Submissions were received from a variety of sources:

- Hospitals and Hospital Groups
- Advocacy groups/Representative bodies
- Private Health Insurance companies
- Regulatory bodies
- Trade Unions and staff representative bodies
- HSE

- Educational institutions/Academics
- Consultants
- Individuals in a personal capacity

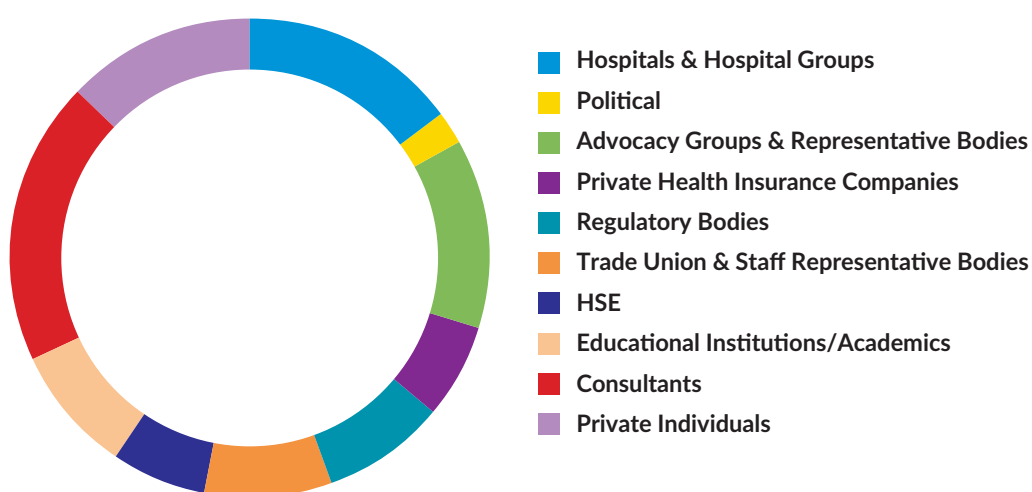


Figure 1 - Submission sources

Themes

Included below is a brief discussion of the most prominent common themes to emerge from the submissions, which included the following:

- Financial
- Equity/Access
- Private Health Insurance
- Consultant Contract
- Recruitment and Retention
- Capacity

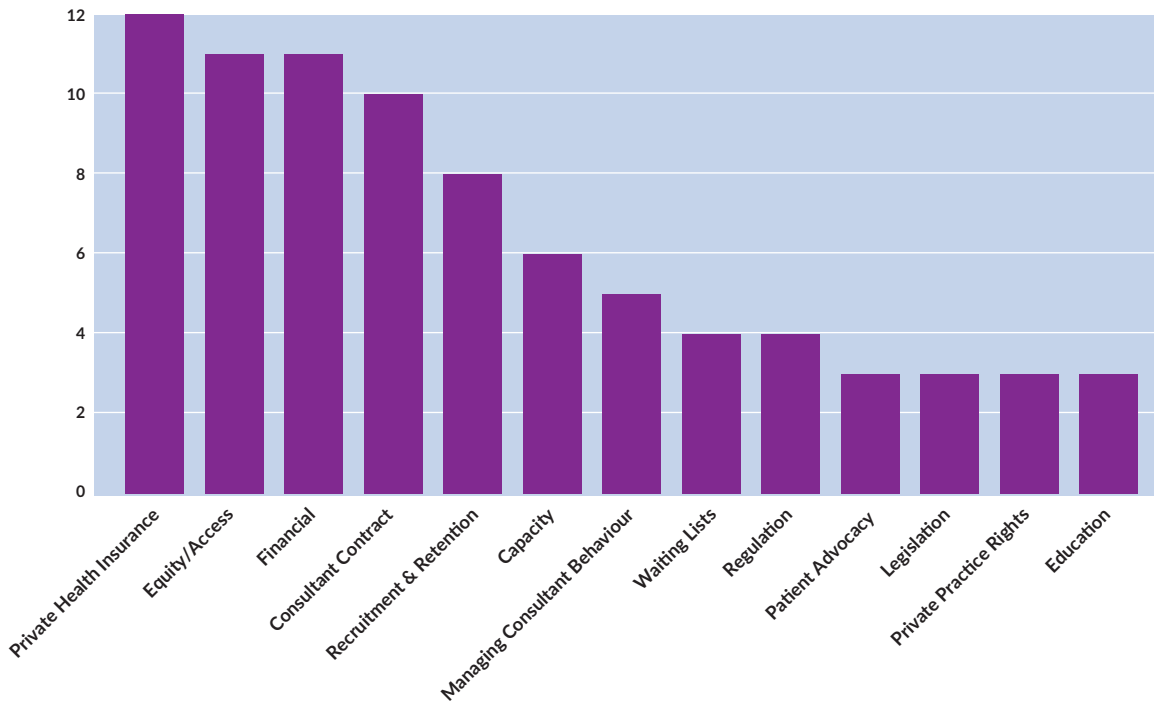


Figure 2 - Themes

Financial

Many submissions noted that hospitals are reliant on the revenue that private practice in public hospitals generates. Hospitals are also encouraged to raise income from private patients and if private practice was to be removed the State would have to step in to replace the resulting budget shortfall. The Irish Medical Organisation's (IMO) submission addressed the financial issue. The IMO was not confident that the shortfall in funding would be 'quickly or easily addressed'⁵, with the likely consequence being a further reduction in funding to the public health budget. They also argued that the financial strain experienced by public hospitals has led to 'pressure being placed on a number of Consultant staff to generate additional private income for their public hospitals.'

In its submission to the Review Group, the HSE noted that currently 'private income... represents about 12% of the revenue funding requirement [of public hospitals].'⁶ They also mention the Sláintecare recommendation to eliminate statutory inpatient charges. The HSE argued that full replacement funding of the statutory inpatient charges and income generated from private patients would be required.

5 IMO Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/42..pdf>

6 HSE Acute Strategy and Planning Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/8.-Pt.-1.pdf>

Equity/Access

A recurring theme concerned access to diagnostics as a key issue. Patients who rely on the public system are at a disadvantage as long delays exist for diagnostics. Those who can afford to pay privately for diagnostics receive a diagnosis more quickly and join the waiting list ahead of a patient who cannot pay. As a consequence those who rely on the public system are diagnosed later and present with a higher level of complexity when they eventually join the waiting list.

Pathways to Universal Healthcare made this argument in their submission.⁷ The team noted that ‘the existence of private care in public hospitals institutionalises inequity in the Irish public hospital system. It means that people who can afford to pay privately or who have private health insurance can gain access to faster care in the public hospital system.’

Some stakeholders welcomed the principle of access being based on clinical need as opposed to ability to pay. The Irish Nurses and Midwives Organisation advised that ‘it is imperative while removing private practice from public hospitals, that the aim of protecting vulnerable sections of society, through ensuring equity of access and access based on clinical need are to the forefront of all decisions.’⁸

Private Health Insurance

The Health Insurance Authority (HIA), in its submission⁹, states that ‘developments in the health insurance market will be greatly influenced by the actual progress of Sláintecare.’

There is a possibility that the cost of holding private health insurance may rise if private practice is removed from public hospitals. This in turn may lead to a drop in the percentage of the population holding private health insurance, with the possibility of many younger members leaving. The HIA notes that ‘the cheapest insurance policies in the current market, mostly non-advanced products (where the dominant benefits are for treatment in public hospitals), would disappear.’

Private health insurers may have to review the types of products that they offer which in turn may change the nature of the Irish private health insurance market.

The HIA notes that ‘eventually, the health insurance market might broadly stabilise but it is impossible to predict the approximate proportion of the population that would retain health insurance and the average price points of policies.’

7 Pathways to Universal Healthcare Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/10..pdf>

8 Irish Nurses and Midwives Organisation Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/29..pdf>

9 Health Insurance Authority Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/09/7..pdf>

The Vhi argues¹⁰ that any ‘removal of public hospital access to privately insured patients will significantly change Private Medical Insurance plan benefits and reduce access to hospitals in general.’ This will mean that members who cancel their plans will rely on the public system and extra funding will be required to meet that need.

Laya Healthcare cautioned that ‘the removal of private practice from public hospitals won’t address the systemic inefficiencies that exist in public hospitals that, if allowed to continue, will undermine the fundamental principles of reform that the Sláintecare Report sets out to achieve’¹¹ while Irish Life Health felt that any ‘erosion of either the health insurance market or collapse of a private hospital would have a severely detrimental impact on the public healthcare system.’¹²

Consultant Contract

The removal of private practice from public hospitals would require a revision of current contractual arrangements with consultants. The HSE notes that if contracts are to be renegotiated there will be a need to ‘maintain a competitive package and ensure public facilities remain attractive.’¹³ The INMO suggested that consultants be afforded the opportunity to move from ‘existing contracts to a direct public contract, working on a seven-day roster system,’ while existing contracts could be retained but not renewed.¹⁴

The Dublin Midlands Hospital Group noted that newly appointed consultants on lower salaries are ‘more heavily reliant on the private income stream to earn a competitive salary.’¹⁵ They felt that such consultants would leave the public system if their earnings were not ‘fully compensated’ in a new public only contract.

A number of stakeholders argued for better supervision of consultants’ working hours and compliance with their contractual obligations. For example, Laya healthcare suggested that the effective governance and monitoring of the current contract determining the public/private ratio of consultant work in public hospital settings would need to be considered¹⁶. In her submission, Deputy Róisín Shortall T.D.¹⁷ highlighted the lack of accountability and external oversight of consultants’ private practice by limiting the amount of private work most consultants could do.

10 Vhi Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/37..pdf>

11 Laya Healthcare Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/27..pdf>

12 Irish Life Health Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/30..pdf>

13 HSE Clinical Strategy and Programmes Division Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/15..pdf>

14 INMO Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/29..pdf>

15 Dublin Midlands Hospital Group HSE Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/45..pdf>

16 Laya Healthcare Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/27..pdf>

17 Deputy Róisín Shortall Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/25..pdf>

Recruitment and Retention

Many submissions noted persistent problems in the recruitment and retention of consultants. If private practice is removed from public hospitals it will be difficult to attract consultants to work in the public system and it may affect the quality of recruits applying for positions.

In its submission to the Review Group, the Royal College of Surgeons in Ireland (RCSI) stated that 'Ireland competes for surgical and medical personnel, and indeed all clinical personnel in a global market.'¹⁸ They noted that highly trained Irish doctors and surgeons can 'earn significantly better salaries' abroad.

The Irish Hospital Consultants Association (IHCA) felt that the proposal would lead to an increase in the number of vacant consultant posts and act as a disincentive to consultants to take up public hospital posts.¹⁹ They cautioned that 'it will drive a significant portion of consultants to change to part-time commitments in the public hospital system, or move to a private hospital or practice abroad.'

Consultants from the Department of Anaesthesiology at South Infirmar-y-Victoria University Hospital noted that their contracts prohibit working outside the hospital²⁰ and the removal of private practice would reduce their income. A number of consultants at the hospital have indicated that they 'would leave the public hospital entirely' while the remainder have said they will expect compensation and new contracts to allow them to work off-site.

Capacity

A number of submissions pointed out that capacity in public hospitals would not improve if private practice were to be removed. Private income would be removed from the public system without generating extra capacity. The Irish Medical Organisation (IMO) suggests that no evidence has been presented 'that capacity exists within the private system to treat patients who currently obtain private care within public hospitals.'²¹

A number of submissions pointed out that most admissions to public hospitals come via the Emergency Department and noted that the main volume of activity that currently is (and would be in the future) carried out in private hospitals consists of elective procedures with a high volume and/or low level of complexity.

The submissions also noted some further concerns such as a requirement for a

18 RCSI Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/13..pdf>

19 IHCA Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/32..pdf>

20 Department of Anaesthesiology at South Infirmar-y-Victoria University Hospital Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/14..pdf>

21 IMO Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/42..pdf>

legislative review and possible amendments to the Health Acts. Patient safety was also an issue of concern.

Comment

The responses received during the consultation came from a variety of different organisations and covered a variety of the themes which the Review Group had been asked to investigate, and it was helpful to receive such a wide variety of views expressed. The Group is grateful to have received the contributions and thanks those responsible for taking the time to share their expertise.

3. Eligibility and activity in acute hospitals

Introduction

Although Ireland has a public healthcare system funded mainly by taxation, it is important to understand the reasons why private activity in public hospitals is such an intrinsic feature of the Irish health service. This chapter is in two parts. The first part examines eligibility to public hospital services in Ireland while the second part looks at the level and nature of activity in Irish acute hospitals.

Eligibility to public hospital services in Ireland

The eligibility framework

It is worth noting the historic context to the development of health services and the current eligibility framework in Ireland.

Wren & Connolly (2017)²² draws on a number of key publications including Barrington (1987)²³, Breen et al. (1990)²⁴ and Wren's own seminal work (2003)²⁵ to describe how Ireland remains a European outlier in not having developed a universal healthcare system. The 2017 article examines "the role of institutions and temporal processes in shaping the politics of healthcare in Ireland and... particularly ... the roles played by the Church and organised medicine; on the nature of the relationships between Church, society, economy and the independent Irish State; and on the critical junctures when reform attempts failed and to which the roots of the modern Irish healthcare system can be traced." Wren also describes many difficulties faced in introducing reforms to Irish healthcare similar to those which had been introduced elsewhere in Europe.

Eligibility in the period up to 2014

Prior to the changes introduced in the Health (Amendment) Act 2013²⁶, the eligibility legislation ensured that access for most of the population was based on ability to pay although, in effect, it ensured higher earners were actively required to purchase insurance to cover potential costs of health treatment. This historic context is important as it is the reason why private practice rights for consultants became a feature of the health service. Furthermore, it contextualises the rise in the numbers holding private health insurance over the period since the early 1970s.

Under the Health (Amendment) Act 1991, a revised eligibility framework was introduced in which all persons ordinarily resident in the State were eligible for all

22 Wren, M., & Connolly, S. (2017). A European late starter: Lessons from the history of reform in Irish health care. *Health Economics, Policy and Law*, 1-19. doi:10.1017/S1744133117000275

23 Barrington, R. 1987. *Health, Medicine and Politics in Ireland 1900-1970*. Dublin: Institute of Public Administration.

24 Breen, R., D. Hannan, D. Rottman, C. Whelan. 1990. *Understanding Contemporary Ireland: State, Class and Development in the Republic of Ireland*. Dublin: Gill and MacMillan

25 Wren, M. 2003. *Unhealthy state - anatomy of a sick society*. Dublin: New Island.

26 Government of Ireland 2013, Health (Amendment) Act 2013, see <http://www.irishstatutebook.ie/eli/2013/act/31/enacted/en/print>

hospital services provided by the public hospital system. This, in effect, introduced a universal access system for public hospitals. However, the “two-tier” system remained in effect due to the “retention of public hospital consultants’ rights to earn private fee income in public hospitals and work simultaneously in public and private hospitals, combined with the growth of private health insurance in response to the cutbacks in public care.” (Wren 2003)²⁷.

We have summarised the eligibility framework in the period leading up to 2014 in Appendix 3.

The current eligibility framework - the Health (Amendment) Act 2013

The Health (Amendment) Act 2013, commenced in January 2014, is the current legislative basis for eligibility and entitlement to acute hospital services. The Act amended Section 55 of the Health Act 1970 to provide that where a patient opts to avail of private inpatient services or waives his/her right to public inpatient services, s/he will be liable for the private patient charges set out in the Health Act 1970 (as amended), irrespective of the type of accommodation made available to the patient. The Health (Amendment) Act 2013 therefore, in addition to defining the two primary categories of eligibility (see below), also continues the tradition of allowing patients to choose to avail of private services in the public hospital system.

The Act addressed a situation identified by the 2010 Comptroller and Auditor General (C&AG) Report²⁸ which noted that almost 45% of inpatients being treated privately by consultants in public hospitals were not paying the designated private patient charge, because they did not occupy a designated private bed. A further 5% were not charged because the patient was accommodated in a non-designated bed, with the result that only 50% of private patient throughput gave rise to a maintenance charge. This was despite the fact that due to treatment costs, the type of room in which a patient is accommodated is not a major contributor to the overall costs of a hospital stay.

The C&AG report found that this position represented a significant loss of income to the public hospital system and to taxpayers and was an indirect subsidy to private insurance companies, who covered the cost of inpatient care in public hospitals for most private patients. The report considered it appropriate that users of private services should pay for the costs of providing these services even when they are provided by a public hospital. The additional income generated as a result of the enactment of the 2013 legislation is a key component of the funding of private services in the public hospital system.

²⁷ Wren, M. 2003. *Unhealthy state - anatomy of a sick society*. Dublin: New Island.

²⁸ Government of Ireland 2011, *Accounts of the Public Services 2010*, Report of the Comptroller and Auditor General, Volume 2 http://www.audgen.gov.ie/documents/annualreports/2010/2010_Volume_2_EN%281.04%29.pdf

Patients admitted to hospital now have the option of being treated as a public or a private patient. A patient's status in this regard is determined according to whether or not the patient chooses to waive the right to receive public inpatient services and/or whether the patient chooses to avail of private inpatient services. In doing so, the patient chooses to be admitted as the private patient of a consultant whose contract permits private practice.

Eligibility to hospital services

As mentioned above, under the current legislation, there are two categories of eligibility for persons ordinarily resident in Ireland. These are:

- Full eligibility (i.e. medical cardholders). Full eligibility is determined mainly by reference to income limits. Determination of an individual's eligibility status is the responsibility of the Health Service Executive. Persons with full eligibility are entitled to a range of services including general practitioner services, prescribed drugs and medicines, all public hospital inpatient services including consultant services, all public hospital outpatient services including consultant services, dental, ophthalmic and aural services and appliances and a maternity and infant care service. Other services such as allied health professional services may be available to medical card holders. With the exception of prescribed drugs and medicines, which are subject to a €2.00 charge per prescribed item (maximum of €20 month per month per individual/family), public health services are provided free of charge to persons with full eligibility.
- Limited eligibility (all others). Persons with limited eligibility are eligible for public hospital inpatient and outpatient services including consultant services, subject to certain charges (see below). They are also entitled to subsidised prescribed drugs and medicines, maternity and infant care services and some community care and personal social services. They may also be eligible for free GP services if eligible for and holding a GP visit card.

In summary, everybody who is ordinarily resident in Ireland is either entitled to access hospital services free of charge or, in the case of those with limited eligibility, subject to co-payments.

Charges for access to public acute hospital services

Persons with limited eligibility are liable to pay statutory charges for using public hospital facilities. The public hospital statutory inpatient charge is €80 in respect of each day during which a person is maintained, up to a maximum payment of €800 in any period of twelve consecutive months. There is also a statutory €100 charge for attendance at Emergency Departments subject to a number of exemptions, including, for example, when the person has a referral letter from a registered medical practitioner.

There is no charge for attendance as a public patient for people referred by a GP for outpatient specialist assessment by a Consultant or his or her team for diagnostic assessments such as x-rays, laboratory tests or physiotherapy.

However, as was described above, patients may also choose to avail of private services in public hospitals and the Act prescribes the relevant charges for such services.

Charges for access to public acute hospital services as a private patient

As described above, patients may choose to avail of private services in public hospitals and the Health (Amendment) Act 2013 prescribes the relevant charges for such services. In these circumstances where a patient chooses to be a private patient in a public hospital, the public hospital is obliged to charge a private inpatient charge which is intended to cover the clinical, administration and maintenance costs associated with facilitating a patient to engage the services of a private consultant. This charge is usually known as either a “private inpatient charge” or a “maintenance charge”. In practice, the vast majority of people choosing to avail of private services in public hospitals use their private health insurance to pay for the service although some may choose to pay the charges directly out-of-pocket.

These Statutory Private Inpatient Charges, which have been applied from 1st January 2014, are levied at the following rates:

	Hospital Category	Daily charge where overnight accommodation is provided in a single occupancy room	Daily charge where overnight accommodation is provided in a multiple occupancy room	Daily charge where overnight service not provided
1	HSE Regional Hospitals, Voluntary & Joint Board Teaching Hospitals	€1,000	€813	€407
2	HSE County Hospitals Voluntary Non-Teaching Hospitals	€800	€659	€329

Table 1 - Statutory Private Inpatient Charges

In addition, the patient is also liable to pay the consultant's fees. This arrangement is a contractual matter between the patient and the consultant rather than through the hospital although, in practice, it is usually managed by the patient's insurer and the consultant.

Emergency admissions

In the case of admissions through an emergency department, patients with private health insurance may opt for private treatment when admitted, some doing so in the belief that the service they will receive is in some way different to public treatment. This might have been the case in the past when private patients may have been provided with a bed in a single or limited occupancy room although this is no longer guaranteed to be the case.

Summary of the eligibility framework

A person who is 'ordinarily resident' (i.e. living in Ireland for at least one year) either has full eligibility or limited eligibility for health services, including hospital services. In relation to acute hospital services, the eligibility rules provide that all users of the services, depending on their eligibility, are entitled either to free services or services available on payment of a relatively modest charge.

Eligibility policy

The current eligibility framework, firmly established in legislation, reinforces the Government policy that the core function of the public hospital system is to provide equitable access to hospital services for public patients. It is clear that all persons ordinarily resident in Ireland are entitled to avail of public hospital services, albeit with modest charges for those who are not entitled to medical cards. However, the fact is that patients who have private health insurance are able to access services provided in public hospitals which would be provided on a public basis anyway. Although the statutory private patient charges are set to recoup the cost (excluding consultants' fees) of the hospital services provided to private patients, in effect, patients would have a right to access these services on a public basis. This is clearly embedded within the legislative framework of the Health Acts.

As private activity is removed from public hospitals, it would be appropriate to revisit the legislation underpinning the statutory charges in respect of private patients. This is not an immediate priority necessary to address private activity in public hospitals and we would not envisage that it needs to be done solely in respect of private activity but as part of the wider commitment in Sláintecare to review the current eligibility framework for all services and consider different options that will enable a phased expansion of universal access to a prescribed range of services.

The Sláintecare Implementation Strategy contains a commitment to introduce legislation to ensure that eligibility for health and social care services has a statutory basis. The Review Group suggests that this opportunity is used by the Department of Health to legislate to ensure that no private activity is conducted in public hospitals from the conclusion of the ten-year Sláintecare implementation period.



Introduce legislation to ensure that public hospitals are exclusively used for the treatment of public patients from the conclusion of the ten-year Sláintecare implementation period.

Public and private practice in an international context

It was stated above that while it is not unusual in other countries to have a mixture of public and private healthcare systems, the public and private health systems operate with a large degree of overlap in Ireland.

The Department of Health Secretariat on behalf of the Review Group engaged with international experts to develop a greater understanding of the international context and to explore options that might be applicable in Ireland.

Evidence briefing by the European Observatory

The European Observatory on Health Systems and Policies, a WHO-hosted network of international healthcare policymakers, delivered an evidence briefing on private practice in public hospitals to assist the deliberations of the Review Group in developing this Report. The briefing took place in Dublin with two staff members of the Observatory accompanied by three visiting experts from Austria, France and Australia in attendance.

The key points shared with the Review Group confirmed the close relationships between public and private practice in the countries examined and in the wider experience of the visiting experts. It was also confirmed that similar issues relating to problems with private practice in public hospitals are present in other countries, most of which have reported difficulties in monitoring and regulation of the practice. Public hospitals are often incentivised to generate extra income from private practice and will often use the practice to recruit and retain doctors. The experts reported that tighter regulation and monitoring of practice activity is key to controlling the effects of private practice on public hospitals and patients. It is worth noting that while the experts agreed that problems relating to regulation and monitoring of practice activity exist, this is within the context of fewer problems generally in accessing public health services. The waiting times for services in the reporting countries are lower than in Ireland so issues such as access and equity are less of an issue.

It is worth noting that there are significant differences between the three countries examined and Ireland. One example is that, unlike Ireland, the three countries have universal healthcare. Another is that while the experts agreed that problems relating to regulation and monitoring of practice activity exist in other countries, this is within the context of fewer problems generally in accessing public health services. In other words, waiting times for services in the reporting countries are lower than in Ireland so issues such as access and equity are less acute problems. There are also significant differences between the reporting countries: for example, 45% of Australia's population has voluntary private insurance cover, a figure much the same as Ireland's, while only 20% in Austria have insurance but fully 95% of French people have voluntary private health insurance (in France, insurance is used to cover co-payments).

A summary of the briefing is included in Appendix 7. In addition, the briefing papers supplied to the Review Group are on the Department of Health website.

OECD Assessment of Private Practice in Public Hospitals

The OECD Secretariat (Health Division) was asked by the Department of Health on behalf of the Review Group to provide information on country experience and empirical evidence on the phasing out of private practice in public hospitals. The OECD reported on health systems where such an intertwining of private healthcare and the public hospital system occurs, the policy or reform directions those other countries may be taking, the evidence that exists internationally on private practice in public hospitals and what possible strategies other countries have adopted to improve recruitment and retention for doctors in hospitals and other countries experiences of oversight and management of consultants.

The main finding of the OECD review was that removing private activity from public hospitals would eliminate the unequal treatment of public and private patients in public hospitals. However, the OECD also reported that it was unclear whether or not the strategy of removing private activity on its own would reduce waiting times. The report also considers the consequences that removal of private activity would have on matters such as the recruitment and retention of doctors, the nature of hospital services and the impact on the private health insurance market. The OECD cautioned that the final effects of removing private activity from public hospitals will depend on implementation design and on the presence of other conditions that might be beyond this specific policy intervention. The Review Group completely concurs with this finding and is of the view that matters such as capacity improvements in acute hospitals, easier access to diagnostic services and to better primary care services and other recruitment and retention strategies beyond the scope of the Review Group terms of reference are essential prerequisites to a successful outcome.

The report produced by the OECD is available on the Department of Health website²⁹.

Summary of relevant international comparisons

The key points noted by the Review Group from the evidence briefing and the report by the OECD confirmed the close relationships between public and private practice in the countries examined and in the wider experience of the experts. It was also confirmed that similar issues relating to problems with private practice in public hospitals are present in other countries, most of which have reported difficulties in monitoring and regulation of the practice. Public hospitals are often incentivised to generate extra income from private practice and will often use the practice to recruit and retain doctors. The experts reported that tighter regulation and monitoring of practice activity is key to controlling the effects of private practice on public hospitals and patients.

The level and nature of activity in Acute Hospitals

Introduction

In this section, we review the evidence in relation to activity in public and private hospitals. In particular, we focus on private activity in public hospitals. However, it is also important to understand the role played by private hospitals in Ireland.

Summary

There are two main types of public hospitals in Ireland, usually described as statutory and voluntary hospitals. The former are those that are owned and managed by the Health Service Executive (HSE) directly and the latter are privately-owned and managed by religious or charitable bodies and are known as voluntary hospitals. Both types of public hospitals are funded by the State. In addition, there are approximately 23 private hospitals operating in Ireland³⁰.

Note on Data

2015 has been used as the year for analysis in order to be consistent with the baseline data used elsewhere by the Department of Health in relation to capacity in the hospital system and by the demand analysis by the ESRI. In other places in this report, 2017 and 2018 data have also been used when relevant, up-to-date data are available.

29 OECD, 2018 Assessing Private Practice in Public Hospitals, OECD Publishing, Paris, available on the website of the Department of Health <http://www.health.gov.ie>

30 There is currently no central oversight or registration system for private hospitals in Ireland. The Health Information and Quality Authority (HIQA) has a role to monitor public acute hospitals against nationally mandated standards. This includes private services being provided in public settings. However, HIQA's remit only applies to the monitoring of these standards in public hospitals and does not currently extend to private hospitals.

The data which have been summarised in this analysis have been primarily taken from two sources:

- Activity in Acute Public Hospitals in Ireland, 2015 Annual Report, Healthcare Pricing Office³¹
- An extract from the Hospital Inpatient Enquiry Scheme (HIPE) provided by Statistics and Analytics Unit in the Department of Health in mid-December 2017 and in June 2018.

The Hospital Inpatient Enquiry (HIPE) scheme, overseen by the HSE's Healthcare Pricing Office (HPO)³², is a health information system designed to collect clinical and administrative data on discharges from, and deaths in, acute hospitals in Ireland³³.

HIPE collects data on day patients and inpatients:

- A day patient is admitted to hospital for treatment on an elective (rather than an emergency) basis and is discharged alive, as scheduled, on the same day. Deliveries are not included.
- An inpatient is admitted to hospital for treatment or investigation on an elective, emergency or maternity basis. Same day inpatients are admitted as inpatients and discharged on the same day, while overnight inpatients stay at least one night in hospital. Maternity discharges are those who were admitted in relation to their obstetrical experience (from conception to six weeks post-delivery) and include delivery and non-delivery discharges.

HIPE reports on activity in hospitals based on discharges, with individual HIPE discharge records representing one episode of care. Patients may be admitted to hospital more than once in any given time period with the same or different diagnoses and this will be recorded as multiple discharges. The HIPE data do not permit analysis of matters such as the number (or type) of hospital encounters per patient. There are some very significant shortcomings in relation to data about activity in acute hospitals.

In public hospitals, there are weaknesses in the data collected and available relating to the over 3.3 million outpatient attendances recorded in HSE acute hospitals in 2015 and no data available relating to private outpatient activity being conducted by consultants who work in public hospitals.

31 Healthcare Pricing Office (2016) Activity in Acute Public Hospitals in Ireland Annual Report, 2015. Dublin. Health Service Executive. Downloadable from http://hpo.ie/latest_hipe_nprs_reports/HIPE_2015/HIPE_Report_2015.pdf

32 For more information, see <http://hpo.ie/>

33 The hospitals that participate in HIPE are listed in Appendix 4.

There is a lack of centrally collected data from the private hospital sector comparable to the data available in the public system through HIPE. Therefore, it is challenging to assess and validate the true levels of activity and the capacity in the private hospital sector. By way of example of the difficulty in ascertaining the true picture of activity in the private sector, two very different rates are reported. In 2017, the Department of Health conducted a direct survey of private hospitals which reported over 390,000 discharges from private hospitals in 2016³⁴. In comparison, according to Wren et al.³⁵, there were 592,000 discharges from the private hospitals providing acute healthcare services in Ireland. The administrative data used in Wren et al. (2017) was provided by the Health Insurance Authority for the purposes of the risk equalisation scheme rather than by hospitals themselves. Therefore, the data would appear to include records of payments by insurers for services available in a wider range of facilities than the private acute hospital sector. This includes, for example, private mental health facilities, drug treatment centres, services provided in hospitals in Northern Ireland etc. It could also be the case that the risk equalisation administrative data records are not comparable to the discharge (or admission) records which form the basis of the main public sector data collection processes. For example, it might be the case that some daycase activity reported on in Wren et al. would be classified as outpatient activity if it were to occur in the public hospital system.

It is clear that better data are required to allow a deeper analysis of all activity in acute hospitals in Ireland, particularly in relation to gaining an understanding of activity in private hospitals.



Comprehensive data should be collected on the nature and scale of activity in the private hospital system equivalent to those collected in the public system.

Hospital activity

There is a large amount of activity occurring in public hospitals in Ireland with a total of 1,664,066 inpatient discharges, approximately 3,298,868 outpatient attendances and 1,293,140 attendances in emergency departments in public hospitals in 2015. In private hospitals, approximately 400,000 inpatient activities were conducted, of which almost 75% are daycases, with the remainder being (overnight) inpatient cases.

While Ireland is not unique in having a mixture of public and private activity in the overall delivery of health services, the extent of intermingling and overlap between the two systems in public settings is unusual. Further details on this matter can be found in the OECD report published on the Department of Health website. As there

³⁴ Health in Ireland Key Trends 2017, Department of Health, <http://health.gov.ie/wp-content/uploads/2018/01/Key-Trends.pdf>.

³⁵ Projections of demand for healthcare in Ireland, 2015-2030: First report from the Hippocrates Model, ESRI 2017 <https://www.esri.ie/publications/projections-of-demand-for-healthcare-in-ireland-2015-2030-first-report-from-the-hippocrates-model/>

is a clear separation between the public and private systems in relation to outpatient activity, this intermingling is most apparent in inpatient and daycase activity.

Inpatient activity

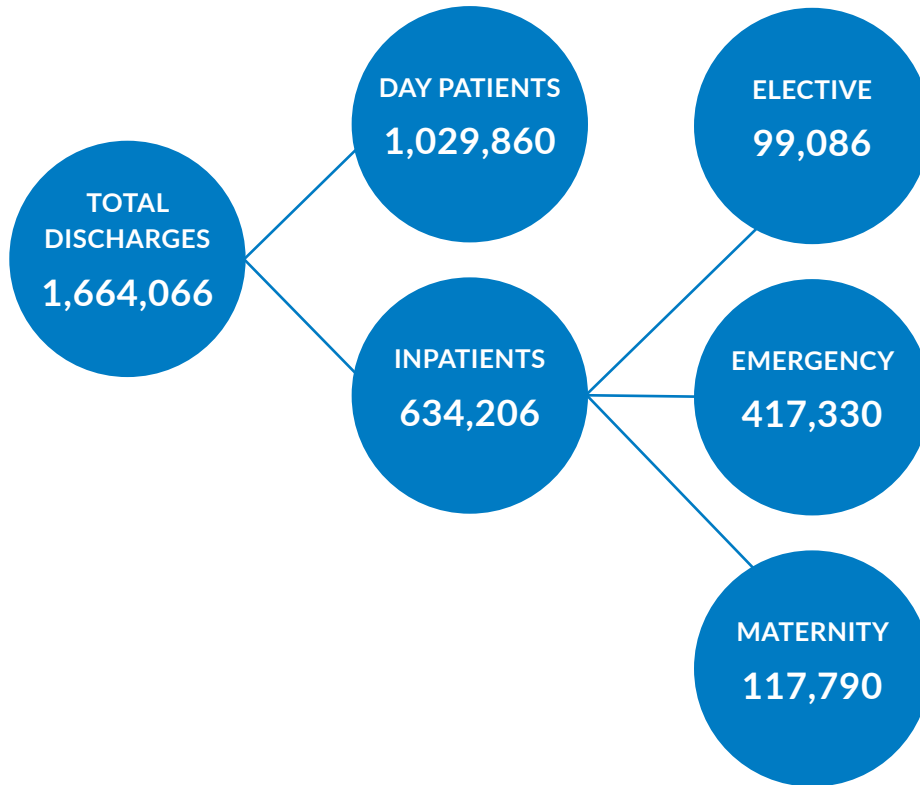


Figure 3: Total inpatient discharges from public hospitals 2015

Inpatient discharges from public hospitals in 2015 was 1.6 million, a 13% increase³⁶ over the period 2011 – 2015. The data confirm that 16% of those inpatient discharges from public hospitals in 2015 were classified as private discharges, whether in direct payment or funded by private health insurance (or a combination of both). It is clear that it is a significant element of all of the activity in our public hospitals.

³⁶ Data for inpatient activity relate to a discharge which is the release of a patient who was formally admitted into a hospital for treatment and/or care and each discharge relates to a specific episode of care.

Inpatient Data

The following table gives a breakdown of the scale of inpatient activity across the public hospital system.

Acute Public Hospital Discharges in HIPE - Summary³⁷			
	2015	% Change 2011-2015	% Change 2014-2015
Total Discharges	1,664,066	13	4.5
Sex			
Male	763,844	12.3	4.6
Female	900,222	13.5	4.4
Age Group			
Under 15 Years	133,638	-1.3	0.8
15-44 Years	464,203	4.7	-0.3
45-64 Years	470,145	13.8	6.4
65 Years and Over	596,080	23.9	7.9
Public/Private Status			
Public discharges	1,398,932	14.9	4.7
Private Discharges ³⁸	265,134	3.6	3.4
Hospital Group Discharges			
Children's Hospitals	52,841		-0.4
Dublin Midlands	310,649		16.3
Ireland East Hospitals	320,647		2.0
RCSI hospitals	244,242		-0.7
Saolta Healthcare Hospitals	299,245		4.0
South/ South West Hospitals	327,700		2.2
University Limerick Hospitals	102,762		5.1
No group	5,980		-3.5

Table 2 - Summary of acute hospital discharges

³⁷ Data for inpatient activity relate to a discharge which is the release of a patient who was formally admitted into a hospital for treatment and/or care and each discharge relates to a specific episode of care.

³⁸ Activity in Acute Public Hospitals in Ireland, 2015 Annual Report of the Healthcare Pricing Office, December 2016

National Trends

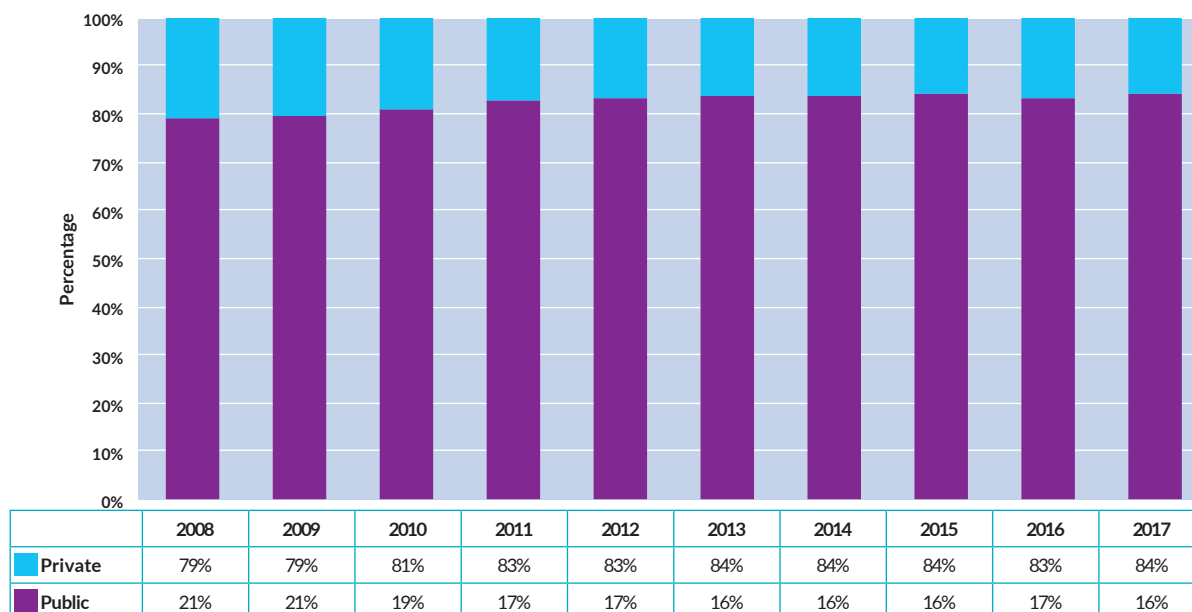


Figure 4 - Public and private discharges in public hospitals

The graph and table at Figure 4 above show the relative levels of public and private activity across all the public hospitals in Ireland between 2008 and 2017. There has been a slight overall trend towards more public activity in public hospitals, and obviously a small reduction in the proportion of private activity (private activity falling from 21% to 16%, and public increasing from 79% to 84%.)

There is a consistent year-on-year rise in the numbers presenting to Emergency Departments (EDs) and this also drives higher numbers of admissions with the HSE reporting that 35% of ED presentations in 2015 led to admission as an inpatient³⁹. Many of these admissions will be admitted as public patients. It has been reported by the HSE and individual hospitals that this is having an effect in reducing private activity and reducing income to hospitals. In addition, the private health insurance providers have been running a campaign advising their customers not to use their private health insurance in certain circumstances. This is believed to be reducing the numbers using their private health insurance when presenting at an emergency department.

While the overall rates in Figure 4 above appear to suggest a levelling off of the trend toward more public activity and a consequent fall in private activity, a closer analysis of recent data suggests that the rate of private activity continues to fall with a suggestion that in 2018 the fall is more pronounced.

39 HSE Annual Report and Financial Statements 2015, see <https://www.hse.ie/eng/services/publications/corporate/annualreportfinancialstatements2015.pdf>

	2016		2017		2018	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun (provisional)	Jul-Dec (projected)
Private activity						
Inpatients	63,833	61,556	58,751	54,577	44,775	36,733
Daycase	77,130	77,274	77,857	72,990	62,300	53,176

Table 3: Recent trends in private activity

Some caution should be exercised in drawing firm conclusions about the more recent data in the table above as the 2018 data is provisional at this stage. However, the fall between 2016 and 2017 is quite pronounced and looks to have continued in 2018.

While the downward trend in the rate of private activity is visible at national level, it is also consistent across hospital groups. However, there are variations between hospital groups in the trend towards more public activity. For example, the trend is more pronounced in the RCSI Hospitals Group (from 19% to 10%) than in the Ireland East Hospital Group (from 15% to 12%). A short analysis of activity across hospital groups is included in Appendix 5. From that, it can clearly be seen that the short and medium term impact of removing private activity will require particular attention in some hospital groups.

Outpatient Activity

According to the HSE's 2015 Annual Report, over 3.3 million outpatient attendances were recorded in HSE acute hospitals. Unfortunately, there is no outpatient equivalent system to HIPE so it is not currently possible to interrogate the data to the same extent as with inpatient data. All outpatient and Emergency Department activity in public hospitals is public activity only although consultants may conduct private outpatient activity on a public hospital campus outside contracted hours.

The HSE's *Guidance to health service management on the treatment of public and private patients*⁴⁰ clearly states that persons referred to outpatient departments must be treated as public patients unless they are clearly identified as private on the initial referral documentation. If they are identified as private patients and wish to be treated privately, they must be referred to an appropriate private outpatient clinic.

The Consultants' Contract 2008 explicitly requires that consultants do not charge private fees in respect of patients attending Emergency Departments in public hospitals or patients attending Public Outpatient Services in public hospitals. This includes consultants performing diagnostic investigations or treatment on patients referred from public Outpatient / Emergency Departments.

⁴⁰ Public and private patients in Public hospitals - Guidance to health service management on the treatment of public and private patients, HSE, Sept 2009 see <https://www.hse.ie/eng/staff/resources/terms-conditions-of-employment/ccontract/public-and-private-patients-in-public-hospitals---guidance-to-health-service-management-on-the-treatment-of-public-and-private-patients-16th-september-2009-.pdf>

Notwithstanding the difficulty in comparing outpatient trend data over the last number of years, it is clear that the scale of outpatient activity is very large and undoubtedly must also be considered when thinking of any changes to general activity that place additional demand on public services.

Activity in private hospitals

While the remit of the Review Group requires examination of private activity in public hospitals, it is essential to acknowledge the very significant role played by private hospitals in Ireland, particularly for those with private health insurance. Furthermore, the State regularly contracts services from the private sector – through investment by the National Treatment Purchase Fund - particularly in efforts to reduce waiting lists. Furthermore, the proposal to remove private activity from public hospitals would appear, on the face of it, to provide opportunities for the private sector but will also pose some challenges.

The data described above (and available in HIPE) relate only to activity in public acute hospitals. Activity in, and the capacity of, the private hospital sector in Ireland also requires analysis, particularly when considering whether any of the private activity which occurs in public hospitals would be likely to move to private hospitals and whether the private hospital system can provide the service.

The Private Hospitals Association, in its submission to the Independent Review Group⁴¹, indicated that the hospitals they represent provide care for 400,000 patients annually in a very wide range of specialities.

Notwithstanding the difficulties with data described earlier, it is clear from the two main reported sources that the private acute hospital sector makes a significant contribution to the overall availability of health services in Ireland, albeit only for those who have private health insurance or who can pay out-of-pocket.

The Wren et al. (2017) analysis estimates that when public and private activity are combined, private hospitals account for an estimated 23% of total hospital admissions, 31% of day-patient admissions and account for 15% of inpatient bed days. Private hospitals also provide some emergency care, with the Private Hospitals Association estimating that Emergency Departments and/or Medical Assessment Units now operate in half of private hospitals⁴².

While similar volumes of insured inpatient bed day activity were estimated to take place in public and private hospitals, the majority (78%) of insured day-patient care was estimated to take place in private hospitals. Similar to demand for other public

41 Private Hospitals Association Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/9..pdf>

42 It should be noted that Emergency Departments in private hospitals do not provide the same range of services and/or operate with reduced opening hours compared to public EDs.

hospital activity, activity rates for private hospital care increase with age and insured inpatient bed day rates in public and private hospitals are very similar across most of the age distribution. Wren et al. also projects that demand for private day-patient care will increase by between 24.2 and 27.9% while demand for inpatient bed days could increase by between 28.1 and 32.0%, by 2030.

It is worth noting that Wren et al. (2017) advises that there are limitations to their analysis, which was constrained by lack of available data. While a number of administrative data sources do exist that could potentially be used to examine private hospital activity in Ireland, accessing and utilising these data for the purposes of research has traditionally presented difficulties.

ESRI analysis of 2015 activity in public and private hospitals

As part of the ESRI Research Programme in Healthcare Reform, funded by the Department of Health, the ESRI was asked to conduct an analysis of the nature, level and the role of private practice in public hospitals for 2015 to help inform the deliberations of the Review Group. The report, which has been published as an ESRI Working Paper and is available on the ESRI website (ESRI, 2018)⁴³ examines the extent to which activity in public hospitals is privately financed, the level and nature of privately financed activity across the hospital system and respective shares of activity in public and private hospitals.

The analysis was limited by data availability and could not include a like-with-like comparison of public and private hospital activity at the level of diagnoses and procedures and in respect of whether inpatient care was emergency or elective. The comparative analysis is limited to aggregated categories of activity, specifically, day patient cases and inpatient bed days.

The analysis confirms a number of key findings including:

Overall public hospital activity

- nearly 1.7 million cases and over 3.5 million inpatient bed days were recorded in public hospitals of which
 - 61% were day patient (excl. maternity)
 - 25% were emergency inpatients
 - 6% were elective inpatients
 - The remainder constituted maternity day patient (1%) and maternity inpatient cases (7%)
 - Inpatient activity in public hospitals is predominantly emergency in nature accounting for 66% of inpatient cases and 74% of inpatient bed days.

⁴³ Keegan C, Brick A, Wren MA, An examination of activity in public and private hospitals in Ireland, 2015, ESRI Working Paper No. 601, ESRI, Dublin, 2018. Paper available at <https://www.esri.ie/pubs/WP601.pdf>

Private activity in public hospitals

- 16% of total cases in public hospitals were privately financed although variation did exist among discharge categories
 - Less than 14% of day patient cases (excl. maternity) in public hospitals were privately financed
 - 26% of elective inpatient cases in public hospitals were privately financed and accounted for under 4% of inpatient bed days
 - 19% of emergency inpatient cases were privately-financed, they accounted for nearly 14% of inpatient bed days

Activity across public and private hospitals

- Public hospitals also provide the majority of both day patient and inpatient care across public and private hospitals combined
 - Approximately 70% of day patient cases are estimated to have taken place in public hospitals
 - Approximately 85% of inpatient bed days are estimated to have taken place in public hospitals
- There is a variation in the relative role public hospitals played in delivering private care
 - Less than 25% of private day patient cases were undertaken in public hospitals
 - Over 50% of total private inpatient bed days were recorded in public hospitals

The analysis concludes that given relative bed supplies in the public and private hospital sectors, the majority of both day patient care and inpatient bed day activity took place in public hospitals. The authors estimated that approximately 70% of day patient episodes were recorded in public hospitals and an even higher share, 85%, of inpatient bed days were estimated to have taken place in public hospitals.

Commentary

As explained above, data were provided from HIPE to assist the deliberations of the Review Group. We have examined inpatient activity in detail and the most obvious conclusion is that the relative rates of private activity vary considerably across hospital groups, across hospitals and across specialties. In relation to some specialties, it would appear that there might be more of an impact from the removal of private practice. This is due to the fact that the relative rates of private activity are particularly high, but it could also be said that even if a small amount of activity is currently carried out

privately in a specialty that has small rates of activity, the impact would be quite high.

It has been argued that some specialties are deserving of special consideration, perhaps through allowing a continuation of private practice within the public system or through some particular compensatory measures. There is no evidence available that supports that contention and, in fact, doing so would just continue the two-tier system in respect of some conditions.

It is noteworthy that the rate of private elective discharges in 2015 stood at 26%. This is an indicator which is particularly noteworthy as elective care is a more managed and planned discharge than that arising from emergency admissions. This is a relatively high rate in comparison to day (14%), emergency (19%) and maternity activity (16%) and illustrates the difficulties in considering where private activity currently carried on in public settings would go on a private basis if the practice is discontinued in public settings.

In 2015, 19% of emergency discharges were privately funded. This is almost unexplainable as it is one part of the hospital system where having private health insurance or a willingness to pay out-of-pocket does not allow any jumping of the waiting list queue. While some patients choose to use their private health insurance in an emergency admission, it is presumably done in the expectation that the treatment or accommodation they receive will be better. However, we would point out that it is almost certainly the case that patients admitted to hospital through an ED will receive the medical treatment they require. Furthermore, since beds are no longer designated as “private” or “public” beds, it is also less and less likely that a patient will be accommodated in a bed in a private or semi-private room as single occupancy rooms in public hospitals are increasingly used for other purposes (such as for isolation or infection-control reasons).

The data which are available show that much of the demand in the public hospital system originates through emergency departments and/or in care of a complex nature. Indeed, the authors of Keegan et al. (2018) conclude that most inpatient care in public hospitals is non-elective. Private inpatients, the majority of whom are emergency inpatients, may not be able to access the care they require in private hospitals.

The HSE, in its submission⁴⁴ to the public consultation process, has indicated some reasons that patients would remain in the public system as including:

- Lack of capacity within the private system
- Lack of an alternative location for their specific treatment in the private system

44 HSE submission to the consultation on private practice in public hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/8.-Pt.-1.pdf>

- Lack of enhanced chronic disease management in the private sector
- The absence of admitting rights into a private hospital for the consultant
- The patient may not have sufficient insurance cover for the private hospital
- Limited private hospital Emergency Departments and other emergency services including 24/7 access to theatre
- Restricted access to Allied Health and Social Care professionals
- Some private hospitals may be unable to deal with significant patient comorbidities

The RCSI, and others, concur with this conclusion. As was pointed out in its submission⁴⁵, “[m]any 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

The RSCI also points out that “it is highly likely that the majority of those who could be treated in private hospitals are already being treated in that sector.” Similarly, the Saolta Hospital Group points out⁴⁶ that “inpatients are primarily admitted through the hospital EDs, 76% of all inpatients”. The University of Limerick Hospital Group contends⁴⁷ that “[t]he private insurance population are likely to continue to use UHL for its emergencies, complex conditions and its cancer related care.” The Dublin Midlands Hospital Group reports⁴⁸ that “[i]npatient activity is largely dictated by the prevalence of Emergency Departments and services. Some hospitals have up to 95% of inpatient admissions linked to the Emergency Department.”

Although it has been argued by some that the successful removal of private activity from public hospitals would require, inter alia, the “transfer” of private patients from

45 RCSI Submission to the Review Group Examining Private Practice in Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/13..pdf>

46 Saolta Group submission to the consultation on private practice in public hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/46.pdf>

47 University of Limerick Hospital Group submission to the consultation on private practice in public hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/47..pdf>

48 Dublin Midlands Hospital Group (DMHG) response to Review of Private Practice in Public Hospitals see <https://health.gov.ie/wp-content/uploads/2018/08/45..pdf>

public hospitals to private hospitals, there are many reasons why private patients are currently treated in public facilities:

- the complex care needs of patients;
- limited geographic access to private hospitals;
- legacy matters such as the historic designation of private beds; or
- where a particular consultant specialty is available.

Patient choice also plays a part in decisions made about where to receive care but many patients rely on referrals by their GP to an appropriate consultant so their decision is less about “where” they will be treated and more about “by whom”.

The analyses referred to above (Wren et al. (2017) and Keegan et al. (2018)) are inconclusive in identifying whether the private system would currently have the capacity to manage a significant influx of private patients that are now managed by the public system. It should also be noted that there are a number of specialities, for example obstetrics and paediatrics, where no private hospital services exist.

Over time, it is likely that the private hospital sector will expand to meet some additional demand, including with the extension of emergency department services, for example. However, we agree that the public hospital system will, of necessity, be required to continue to provide an extensive range and complexity of services.

In his submission⁴⁹, Dr Brian Turner of the Department of Economics, University College Cork cites research he has carried out⁵⁰ that showed that private patients discharged from public hospitals tended to have shorter average lengths of stay, despite having a relatively more complex mix of treatment. He cautions that the reasons for this are unclear and warns that if a similar situation were to pertain after the removal of private practice from public hospitals, it would mean that the number of additional public patients treated may be less than the number of private patients whose treatment would be removed from public hospitals.

Returning again to the scale of private activity in the public system, it is clear that challenges exist with the capacity of the public system to respond to the demands placed upon it.

It is somewhat simplistic to argue that removing private practice from the public system would automatically increase public capacity without also making other changes to the system. In fact, it is clear that additional resourcing of such public

49 Dr Brian Turner Submission to the Independent Review of Private Practice in Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/35..pdf>

50 Brian Turner and Edward Shinnick (2012): Private Versus Public Age-Related Utilisation of Public Hospital Services in Ireland. The Geneva Association Health and Ageing Newsletter, No. 26, April 2012. Geneva: The Geneva Association.

activity (for example, for staff, beds, finance etc.) would have to be provided to allow the additional capacity to be utilised.

More generally, and while it is a well-known and well-accepted fact, it must be pointed out that the scale of the demands arising from emergency departments is the main driving force in how acute hospitals operate on a day-to-day basis. The continuing growth in hospital emergency workloads delays planned admissions and means less scope for hospital managers to plan elective care. Delays in planned admissions also lead to longer waiting lists.

Capacity of acute hospitals

A huge demand is placed on our public hospitals. The 2018 Health Service Capacity Review⁵¹, found that Ireland has among the highest acute bed occupancy rates at 94% in the developed world, significantly ahead of the OECD average of 77.3%. The Review also pointed out that this is an average rate over the entire health system so the system, in parts, must be working at full capacity, if not above full capacity. We have been told that during periods of very high demand many hospitals regularly operate at well over 100% occupancy rates. This would suggest that the current number of beds in the Irish acute hospital system is not sufficient to meet demand.

These very high bed occupancy rates and very long waiting times for patients to access public services would seem to suggest that there is not enough capacity to respond to demand. Likewise, the ESRI has quantified a high level of unmet need in its 2017 report for the Department of Health⁵². Furthermore, our health service is very hospital-centric and there are deep-rooted structural inefficiencies in the system that are regularly highlighted. For example, the Sláintecare Implementation Strategy recognises “a system that involves inefficiencies and duplication, and that is often designed around institutional and administrative concerns, rather than patients.” While it is accepted that some progress has been made in recent years, more will need to be done to improve the design of the system to ensure it is patient-centric and to develop new models of care to deliver more effective and integrated care.

The National Development Plan commits €10.9bn to investment in health infrastructure and this includes funding for a number of priority actions in Sláintecare. This includes additional capacity as recommended in the Health Service Capacity Review (2018), to provide:

51 Health Service Capacity Review, Department of Health, 2018, See <https://health.gov.ie/blog/publications/health-service-capacity-review-2018/> and

52 Projections of demand for healthcare in Ireland, 2015-2030: First report from the Hippocrates Model, ESRI 2017, see <https://www.esri.ie/publications/projections-of-demand-for-healthcare-in-ireland-2015-2030-first-report-from-the-hippocrates-model/>

- 2,600 acute hospital beds
- 4,500 additional long and short-term beds
- New elective-only hospitals in Cork, Dublin and Galway
- A modern ehealth and ICT infrastructure
- Additional Primary Care facilities with greater access to diagnostics

Conclusion

The activity rates in our public hospitals reflect the demand placed on the system and the mechanisms through which treatment services are provided.

When private activity is discontinued much of the activity which is currently private activity is likely to remain in the public system due to its nature, primarily because there is no alternative service in the private sector. This includes emergency admissions, maternity services, national specialty services, activity of high complexity and activity with low volume. It will include activity where no alternative service is available in the private sector or where no alternative service exists in close geographic proximity. In fact, much of this activity will continue in public acute hospitals regardless of whether private activity is allowable or not.

On that basis, the Review Group concludes that removing private activity from public hospitals is not a “magic bullet” and is unlikely to generate significant additional capacity in the short term as much of the activity will remain in public hospitals and will simply become public activity.

4. Patients

Introduction

It is an accepted principle that access to healthcare should be on the basis of clinical need rather than on ability to pay. Even a cursory examination of hospital services in Ireland immediately confirms that there are many serious problems in relation to access to services.

Access to services is perhaps even more important than eligibility when it comes to individual patients requiring services provided in an acute hospital. After all, if a person is eligible for a service but is not able to avail of it in a timely manner, they will experience negative outcomes.

It is in accessing services that the most obvious inequity in Irish hospital services becomes immediately apparent.

Access to public services

In the normal course of events, a patient requiring access to hospital services, for example in the first instance through a referral by their GP, who does not have private health insurance and does not have the means or inclination to pay “out-of-pocket” will be referred to a consultant operating in a public capacity in a public hospital. They will then join a waiting list. If their care needs are not urgent, this may be for a very long time.

Access to private services

In contrast, if a patient wishes to access services on a private basis, their GP will refer them to a consultant who works in a private capacity, either in a public hospital or in a private hospital. The treating consultant in a public hospital will be a consultant with a public contract who has private on-site practice rights. The treating consultant in a private hospital may either work entirely in the private sector or may be a consultant with a public contract who has private off-site practice rights. The patient will join a waiting list. However, in comparison to accessing a public service and regardless of comparative urgency needs and of the location where the service is provided, the waiting times are reported to be considerably shorter.

In cases where the consultant conducts private activity in a public hospital, the physical infrastructure and the other staff (non-consultant hospital doctors, nursing, care workers and administration) is provided and funded as a public service. A statutory charge is levied on the private patient for the provision of this service as was described in Chapter 3.

Waiting Lists

In addition to the activity which is taking place in the public hospital system, the numbers of people on waiting lists (and the length of time they are waiting) also indicates the strain that the public hospital system is under.

The National Treatment Purchase Fund (NTPF) is responsible for collecting and validating all waiting lists for public hospitals. These data are published monthly and are available on the NTPF website at <http://www.ntpf.ie/home/nwld.htm>. The published NTPF figures for the end of October 2018 show that more than 516,000 people are on the outpatient waiting list and 72,000 people are on the inpatient/daycase waiting lists. It is notable that approximately 12,000 people are waiting more than a year for inpatient care and 150,000 people are waiting more than a year for an outpatient appointment.

It is not unusual for people to have to wait a certain amount of time for access to hospital services and most countries have some formal waiting time protocols. For example, in England, the maximum waiting time for non-urgent consultant-led treatments is 18 weeks from the day an appointment is booked through the NHS e-Referral Service, or when the hospital or service receives a referral letter⁵³. Even in the most efficient health services, waiting times are often exceeded, but the situation here in Ireland highlights very clearly the level of unmet demand in the hospital system.

The lengthy waiting lists cause two problems. First, it is generally accepted that, by virtue of the long waiting times, many patients are being treated later than is ideal and consequently require more complex treatment. Secondly, many people who are waiting for appointments are presenting at emergency departments because they develop an urgent requirement for care or because they realise they will be treated more quickly.

A recently published paper prepared by Irish Government Economic & Evaluation Service staff in the Department of Public Expenditure and Reform has pointed out that waiting list numbers continue to grow⁵⁴. Between 2014 and 2017, the average number of people waiting on a day case procedure increased by 59% while the average number of those waiting on an inpatient procedure increased by 46%. The proportion of those waiting over 15 months for a day case procedure increased by 10 percentage points while there was a 14 percentage point increase in the proportion waiting for an inpatient procedure.

53 Guide to NHS waiting times in England, see <https://www.nhs.uk/using-the-nhs/nhs-services/hospitals/guide-to-nhs-waiting-times-in-england/> (accessed 12 September 2018)

54 Spending Review 2018 Hospital Inputs and Outputs: 2014 to 2017, Department of Public Expenditure and Reform, available at <https://www.per.gov.ie/wp-content/uploads/25.-Hospital-Inputs-and-Outputs.pdf>

Waiting times

The scale of numbers on the waiting lists is a cause for concern. The Sláintecare Implementation Strategy acknowledges that access to public acute hospitals in Ireland is inequitable.

As stated above, it is almost certainly the case that patients who choose to access private services are seen more quickly than people on public waiting lists, particularly in relation to outpatient appointments and diagnostic procedures but also in the case of elective care.

Access to healthcare is unequal; the tiers we have created are both unfair and a fundamental barrier to progress. Ireland is the only western European health system that does not provide universal access to primary care. In addition, access to public acute hospitals is inequitable. The majority of our population pays out-of-pocket fees to access primary healthcare and 45% of the population purchase inpatient health insurance plans, which can provide faster access to private health services in both public and private hospitals. This inequality of access is embedded in our current system and creates barriers and perverse incentives that stand in the way of doing the right things for patients that need care. Moreover, wider health inequalities persist among some groups of the population.

Figure 5 - Extract from the Sláintecare Implementation Strategy

However, no comprehensive data are available that would clearly allow a comparison between waiting lists and waiting times for public and private patients. It is clear that private health insurance is sold on the basis that access to health services is readily available with minimal waiting times while the public health service is plagued by very long waiting lists. As was described in Wren & Connolly (2017)⁵⁵, “[a]lthough a nominally common waiting system was introduced in 2008, privately insured patients’ faster routes of access to initial consultations in consultants’ private rooms and to diagnostic tests, ensure that they gain faster access to public hospital elective care while public patients can experience long waits”. Research conducted by the Irish College of General Practitioners on behalf of the Irish Cancer Society in 2016⁵⁶ reported that “doctors...face a struggle in securing timely tests to provide diagnoses for public patients.” The research found:

55 Wren, M., & Connolly, S. (2017). A European late starter: Lessons from the history of reform in Irish health care. *Health Economics, Policy and Law*, 1-19. doi:10.1017/S1744133117000275

56 O’Shea MT, Collins C. Access to diagnostics used to detect cancer. Dublin: Irish College of General Practitioners and Irish Cancer Society; 2016

“There was a striking difference in access for patients in the public system versus those in the private system for the majority of diagnostic tests. Similar to previous findings, the public system waiting times showed a wider distribution with a higher mean delay in all cases when compared to the private system.

“The majority ...of respondents reported that a patient’s ability to pay privately ‘always’ or ‘usually’ affects access to referral services. Delays in accessing diagnostics forces many patients to pay for scans and tests privately to secure diagnosis. As a result, a patient’s ability to pay is linked to their ability to access diagnostics used to detect cancer in a timely manner.”

The report shows the scale of problems in accessing public diagnostic services. Other than for chest x-rays, median access times to other diagnostics such as CT Scans, MRI scans and endoscopies range from 30 to 100 days. In comparison, access to equivalent services in the private sector range from 5 to 10 days. Notwithstanding the fact that access to public diagnostic services might be more appropriately delivered in primary and community care settings, this is a clear indication of the severe delays accessing public hospital services.

Maintenance of Waiting Lists

The consultant contract provides that a common waiting list operated by the public hospital will apply to both public and private patients undergoing diagnostic investigations, tests and procedures on an outpatient basis in public hospitals. It directs that status on the common waiting list will be determined by clinical need only.

In relation to inpatient, daycase and planned procedures, the protocol developed by the National Treatment Purchase Fund⁵⁷ provides useful guidance to ensure that there is a consistent and standardised approach to the management and scheduling of patients on Inpatient, Day case and Planned Procedure (IDPP) waiting lists within each hospital and across hospital groups.

Patients who cannot afford to pay for outpatient activity should not be disadvantaged in comparison to those who can pay (or whose insurance pays) and are then able to “skip ahead” in their care pathways in the public system. The NHS has produced useful guidance which sets out principles on boundaries between (public) NHS and private care when making decisions when NHS patients want to pay for additional care⁵⁸.

Accessing services in private hospitals

A number of matters were raised with the Review Group in relation to patient safety issues in private hospitals. For example, in its submission⁵⁹, Patient Focus said that “regulation of the safety and quality of care is ... embedded in the public sector” and

57 National IDPP Waiting List Management Protocol, National Treatment Purchase Fund, see <http://www.ntpf.ie/home/nwlg.htm>

58 Guidance on NHS patients who wish to pay for additional private care, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/404423/patients-add-priv-care.pdf

59 Patient Focus Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/41..pdf>

reported that there are “problems of accountability and transparency in some areas of the private sector.”

One of the functions of the Health Information and Quality Authority (HIQA) is to monitor public acute hospitals against National Standards for Safer Better Healthcare, the national standards for acute hospital settings mandated by the Minister for Health in 2012. The Standards set out a desired level of service and were designed for use in all healthcare services, settings and locations. However HIQA’s remit does not currently extend to the monitoring of these standards in private hospitals. The Review Group welcomes the commitment in the Sláintecare Implementation Strategy to progress the Patient Safety Bill and the Patient Safety (Licensing) Bill to include clinical governance and patient safety operating frameworks across hospitals, to implement a hospital licensing scheme and to extend HIQA’s remit to the private sector. These are necessary actions to ensure the delivery of safe, quality and patient-centred care for all patients, and all patients availing of treatment in public and private hospitals and facilities should have trust and confidence in the services being provided.



The Department of Health should ensure that HIQA’s quality and safety regulatory functions are extended to all healthcare settings.

Commentary

All patients with similar clinical need should be seen in strict chronological order. In a number of submissions and during meetings with stakeholders, we were told of problems with waiting lists for public patients:

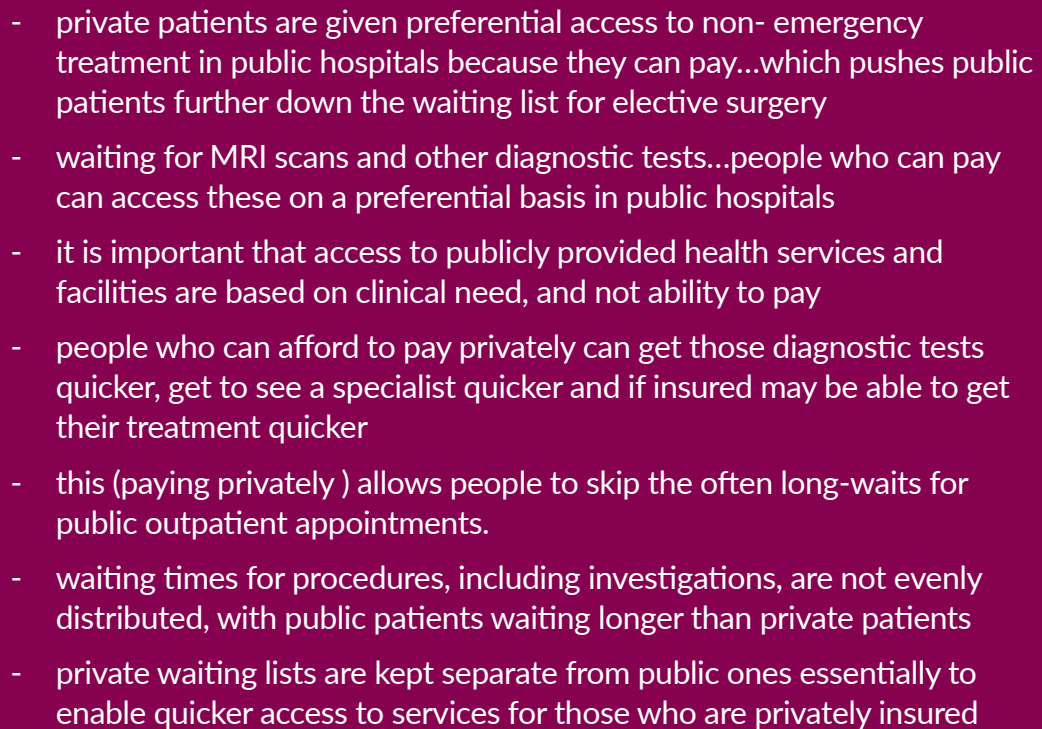
- 
- private patients are given preferential access to non- emergency treatment in public hospitals because they can pay...which pushes public patients further down the waiting list for elective surgery
 - waiting for MRI scans and other diagnostic tests...people who can pay can access these on a preferential basis in public hospitals
 - it is important that access to publicly provided health services and facilities are based on clinical need, and not ability to pay
 - people who can afford to pay privately can get those diagnostic tests quicker, get to see a specialist quicker and if insured may be able to get their treatment quicker
 - this (paying privately) allows people to skip the often long-waits for public outpatient appointments.
 - waiting times for procedures, including investigations, are not evenly distributed, with public patients waiting longer than private patients
 - private waiting lists are kept separate from public ones essentially to enable quicker access to services for those who are privately insured

Figure 6 - Quotes from various submissions to the Group

These points have been stressed here because the empirical data or hard evidence to prove the inequity between public and private patients in accessing services in public hospitals do not exist and yet this is the lived experience for very many members of the public who have needed access to hospital services but who cannot afford private health insurance. We were also told by a number of stakeholders that, in some cases, private patients “move up” the waiting lists ahead of public patients, usually through reclassifying the cases as urgent although no hard evidence is available to support this contention.

It is clear though that it is a common experience for many that they access services less quickly if they are a public patient.

5. Consultants

Introduction

In this chapter we examine issues in relation to the consultant contract.

Background

All consultants employed in the public health service are employed under contracts of employment agreed between the HSE, the Department of Health and the medical consultants' representative organisations. Approximately 3,100 consultants held contracts of employment in the public health service in December 2017, of which approximately 2,700 are employed in public acute hospitals⁶⁰.

All new appointments are made under the terms of the 2008 contract framework and all consultants are now appointed as Type A, Type B or Type C consultants (see below for descriptions). Consultants who were in employment in 2008 under the terms of prior contractual arrangements, primarily 1997 and 1991 contracts, were allowed to change to 2008 contracts (Type A, B, B* or C) although a number retain their 1997 contracts (14% of the total working in acute hospitals.)

Consultants who hold 1997 contracts or who hold Type B, Type B* and Type C contracts 2008 may engage in privately remunerated professional medical/dental practice as determined by their contract type.

The profile of consultants in HSE-funded posts

The age and gender profiles of consultants are indicated in Figure 7⁶¹.

60 The remainder are employed in non-acute settings such as in mental health services or community settings. The terms of reference of the Review Group referred specifically to public acute hospitals so consideration has been given only to matters in public acute hospital settings.

61 This information is taken from the Doctors Integrated E-management System (DIME) and is dependent on Hospital Groups inputting details on their consultant workforce - there may be gaps in the data supplied compared to that held within hospitals.

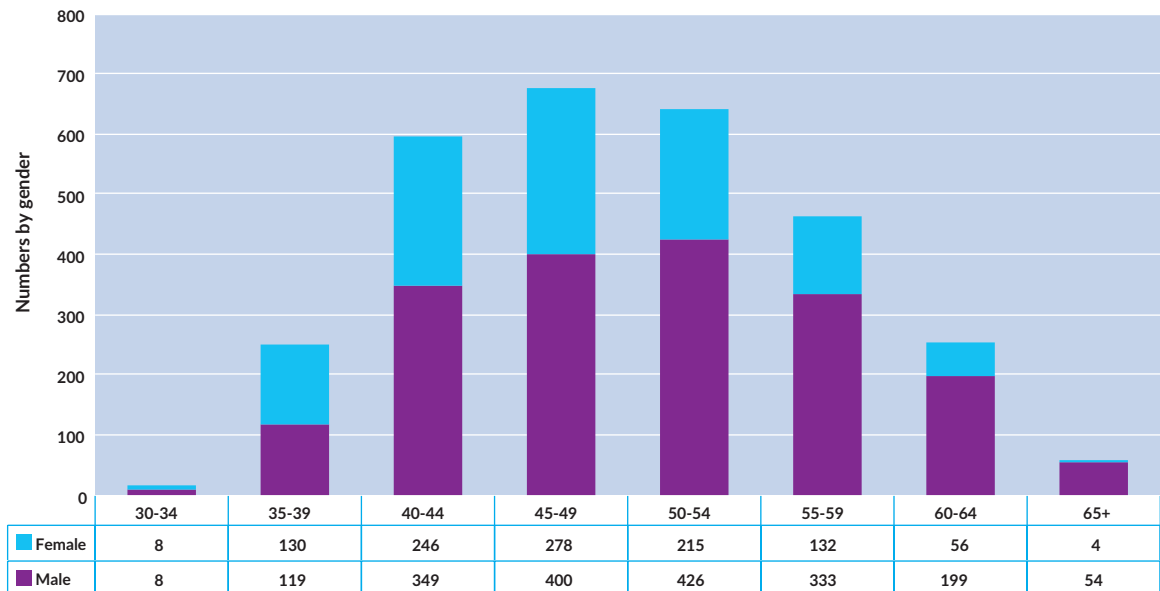


Figure 7 - Age and gender profile of consultants in HSE-funded posts. Source: HSE

While there are relatively equal numbers of male and female consultants in the 30-34 and 35-39 age categories, males have significantly higher representation in older age categories. There are also considerably more male consultants than female in certain specialties. This will change over time as increasing numbers of female doctors are employed in the health service.

As in many other workplaces, it is likely that increasing numbers of doctors working in the health service will seek opportunities for part-time and flexible working rather than strict 39-hour contracts. It is likely that public contracts of alternative working patterns, perhaps three-day or four-day working weeks (with pro-rata pay and other terms and conditions) will increasingly become a feature of employment as a consultant.

It is estimated that 27% of consultants will retire over the next decade (i.e. consultants currently aged 55 and over will be expected to retire over that period).

Doctor numbers

There has been significant growth in the number of doctors employed in the public health service over the last ten years with the numbers of consultants growing by approximately a third in that time. Notwithstanding the recruitment and retention challenges which currently exist (see below), the number of consultants employed in the public health service has increased by 118 in the 12 months to end August 2018 and by 479 in the past five years⁶².

⁶² See Parliamentary Question 424 of 02 October 2018 (39883/18) to the Minister for Health, https://www.oireachtas.ie/en/debates/question/2018-10-02/424/#pq_424/#pq_424

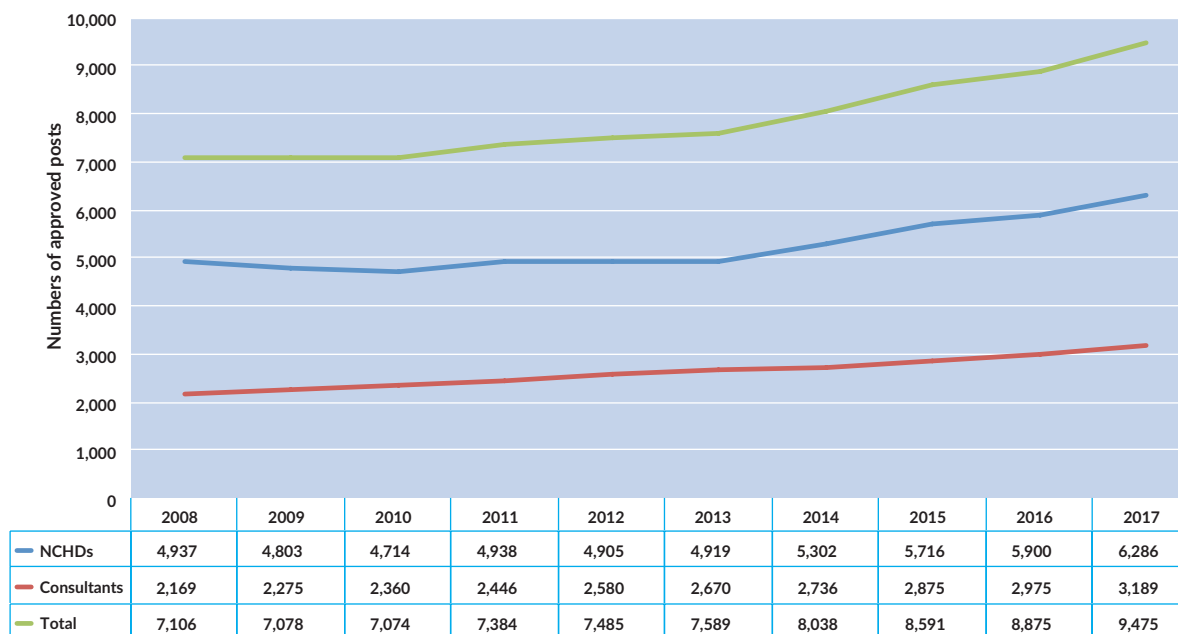


Figure 8 - Growth in doctor numbers 2008 - 2017

It should be noted that the Hanly Report⁶³ from 2003 recommended that there should have been 3,600 consultants working in the health service by 2013. The actual numbers are significantly below that, although the report also recommended a commensurate overall reduction in the numbers of Non-Consultant Hospital Doctors (NCHDs) in that time in order to achieve a consultant-provided service which has not happened.

As the numbers are so significantly below what is recommended, it would be reasonable to expect that every effort possible would be made to ensure that adequate numbers of consultants are employed in public hospitals. This would provide an opportunity for the HSE to adequately consider issues such as the makeup of the workforce over the coming years. The consideration of relevant questions about consultant pay and recruitment and retention are below.

The 2008 contract provisions

The current contract, under which consultants are engaged in the HSE, was agreed in 2008. The Consultants' Contract 2008 reflects the nature of the Irish health service with public hospitals providing public and/or private access to care. In relation to regulating the volume of private activity that consultants can engage in, it built on the provisions contained in Consultant Contract 1997. The provisions in the 1997 contract provide that a consultant's overall proportion of private to public patients should reflect the ratio of public to private stay beds designated under the 1991

63 Department of Health and Children, 2013, Report of the National Task Force on Medical Staffing see <https://health.gov.ie/blog/publications/report-of-the-national-task-force-on-medical-staffing-hanly-report-2/>

Health (Amendment) Act⁶⁴. While the formal designation of beds between public and private was superseded by the provisions of the Health (Amendment) Act 2013 that allowed for charging by the hospital of private patients in public beds for the services provided, consultants who hold the 1997 contract continue to be subject to the ratios arising from the bed designation process.

When the 2008 Contract was being negotiated, the intention was to promote equity of access to services, including consultant services, for public patients. At the time, it was envisaged that co-located hospitals would free up over 1,000 designated private beds for public patients and consultants would be able to work in the privately owned and managed hospitals on the same sites as public hospitals. However, no co-located facilities were developed and the plan was ultimately abandoned.

With regard to consultant access, the contracts offered were structured to promote greater access for public patients to public hospital beds and the pay rates attached to them were also structured to do so with higher rates for consultants moving to public-only contracts.

Four contract types were developed as follows⁶⁵:

- Contract Type A requires a full public patient commitment and with significantly higher rates of pay than the contract types that permit private practice. Consultants holding a Type A contract are not permitted to engage in privately remunerated professional practice.
- Contract Type B - Consultants holding a Type B contract may undertake private practice on-site, up to a limit of 20% of activity on a casemix-adjusted basis, and limited off-site private practice in cases where the individual consultant previously held a Category 1 or Category 2 contract under Consultant Contract 1997. Serving consultants whose public to private ratio in 2006 was greater than 20% are permitted to retain this higher ratio, subject to an overriding maximum ratio of 70:30%.
- Contract Type B* - Consultants holding a B* Contract previously held a 1997 contract before transferring to the 2008 contract. They may engage in onsite and off-site private practice and their inpatient and outpatient private practice activity in the public hospital is subject to a 20% maximum limit. Serving consultants whose public to private ratio in 2006 was greater than 20% are permitted to retain this higher ratio, subject to an overriding maximum ratio of 70:30%.

Contract Type C - Consultants holding a Type C Contract may engage in on-site and

64 Typically, 20% or more beds in public hospitals were designated as private beds. The rate varied significantly across the hospital system with some regions having higher private designations than others due to geographic proximity to private hospital facilities.

65 The provisions which have been itemised here are extracts from the contract which should not be seen in isolation from the other provisions. Consultants' Contract 2008 and other related documentation is available from the HSE website at <https://www.hse.ie/eng/staff/resources/terms-conditions-of-employment/ccontract/>

off-site private practice. Their inpatient and outpatient private practice activity in the public hospital is subject to the 20% maximum limit.

As can be seen above and particularly from the numbers of consultants allowed to practise in a private capacity, the Consultant Contract is, therefore, central to the private activity that occurs in public hospitals. It should also be noted that the contract provisions are closely linked to the history of private practice in public hospitals and to the eligibility framework discussed in chapter 3.

The following table sets out the numbers of consultants employed in public acute hospitals, the types of contracts they hold and whether and where they may practise in a private capacity.

Consultants in public acute hospitals								
Contract	Type / Category	Number	Access to private practice	Measurement mechanism	On-site	%	Off-site in private rooms only	Off-site in private hospitals or clinics
2008	Type A	169	No	Volume x complexity via HIPE etc.				
	Type B	700	Yes		700	up to 20%		
		1,129	Yes		1,129	up to 30%	1,129	
	Type C	136	Yes		136	up to 20%		136
	Type B*	301	Yes		301	up to 30%		301
1997	Category 1	204	Yes	Aligned with private bed designation	204	10-40%	204	
	Category 2	163	Yes		163			163
Total		2,802	2,537		2,633		1,333	600

Table 4 - Breakdown of consultant contract types, December 2017 (Source: HSE)

In summary, as can be seen from the table above,

- There are currently six main contract types in operation
 - two of which (Category 1 and Category 2) are held by a small number of consultants (14%) under the terms of the 1997 contract framework and
 - four of which (Type A, Type B, Type B* and Type C) came in to existence in 2008.
- Just 6% of consultants employed in public acute hospitals hold contracts with no private practice rights (i.e. Type A contracts)
- 94% of consultants employed in public acute hospitals are allowed to conduct private practice in a public hospital site with over 1,300 of those consultants conducting private activity off-site in private rooms (primarily outpatient consultations)
- 22% of consultants employed in public acute hospitals are allowed to conduct private practice off-site in a private hospital or clinic (Type C, Type B* and Cat 2 1997 contracts)

A significant trend highlighted in a recent report by the Comptroller and Auditor General⁶⁶ is the fall in the proportion of consultants holding Type A contracts – the contracts with no private activity - from 29% in 2009 to 17% in 2017 which is a drop from 684 to 548. Just 169 consultants are engaged on Type A contracts in public acute hospitals⁶⁷. In the context of examining private activity in public hospitals, this fact is significant as Type A consultants are the only consultants who conduct public activity only.

There are a number of reasons for this decrease in Type A contracts:

- According to the Department of Health, salary increases due after the 2008 contract was agreed were not paid and pay cuts were subsequently introduced under the Financial Emergency Measures in the Public Interest (FEMPI) Act 2009. This made Type A posts less attractive to prospective applicants as the salary differential between Type A and Type B or C contracts was not significant enough to offset potential earnings from private practice.
- Hospitals are more likely to attract applicants for vacant positions when they advertise the post as a Type B contract as, in addition to a full public salary, the prospective applicant will also be allowed to earn additional income through private practice. Clearly, this discourages hospitals from offering Type A contracts as they feel they will attract fewer applications.

66 Report on the Accounts of the Public Services 2017, Comptroller and Auditor General, see http://www.audgen.gov.ie/viewdoc.asp?fn=/documents/annualreports/2017/Report/EN/Report_Accounts_Public_Services_2017.pdf (paragraph 16.23)

67 The remainder work in non-acute settings.

- Hospitals are not permitted to charge patients seen by Type A consultants (other than the statutory inpatient charges described in Chapter 3). By allowing consultants to conduct private activity on their site, hospitals raise private patient income from patients being treated by consultants working in a private capacity. Clearly, when operating within constrained financial circumstances, it is in a hospital's interest to maximise the income they receive from private activity to the greatest extent possible.
- It has also been argued that attracting new consultants in to the system is more difficult since the starting pay is lower than the pay for existing consultants.

This reduction in the numbers of consultants appointed to Type A contracts indicates that it is more advantageous for the employer and for the prospective employee when Type B or Type C contracts are on offer as opposed to the more limited options for public-only contracts.

As a result, the HSE and individual public hospitals established and/or funded to provide public services have an incentive to pursue policies which encourage employees to work privately.

Compliance with contracts

Media attention has highlighted problems with the management of the Consultant Contract, particularly relating to oversight and management of the ratio of public to private work. While it is acknowledged that the majority of consultants is complying with their contracts and, in fact, it is known that many consultants work in excess of their publicly contracted hours, the evidence does not currently exist which might prove the extent or otherwise of compliance at individual consultant level.

Government policy is to ensure that there is equitable access for public patients to public hospitals and that the core purpose of the system is to provide services for public patients. Although a proportion of activity in public hospitals involves the provision of care to private patients, the Minister for Health has repeatedly indicated that the proportion of private activity should be appropriately controlled and that the costs of provision of services to private patients are recouped by public hospitals⁶⁸.

Given the scale of private activity in the public hospital system and the number of consultants engaged in such activity, the failure to monitor compliance is notable, particularly when relevant provisions were included in the 2008 contract to do so and when concerns were raised as far back as the 2010 Comptroller and Auditor General Report⁶⁹ on the charging for private services.

68 See, for example, Parliamentary Question 205 of 10 May 2017 (22300/17) to the Minister for Health https://www.oireachtas.ie/en/debates/question/2017-05-10/205/#pq_205/#pq_205

69 Accounts of the Public Services 2010 Vote Management, Report of the Comptroller and Auditor General, Volume 2, Government of Ireland 2011, <http://www.audgen.gov.ie/viewdoc.asp?DocID=1327>

There is quite a difference between the 1997 and 2008 contract provisions in relation to how compliance might be monitored. The 1997 contract provides that *[the consultant...] may engage in private practice in accordance with the terms of the Memorandum of Agreement.*⁷⁰ The Memorandum of Agreement (see extract included in Appendix 6) provides that the consultant's overall proportion of private to public patients for on-site private practice should reflect the ratio of public to private stay beds designated under the 1991 Health (Amendment) Act. This Act required that all public hospital beds be classified as public, private or non-designated. However, since the enactment of the Health (Amendment) Act 2013, beds are no longer designated as "private" or "public" beds. Given this change, the original basis for monitoring compliance no longer exists.

For consultants holding 2008 contracts, the basis for the regulation of private practice is provided in section 20 of the contract. This provides:

- that the volume of private practice may not exceed 20% of the consultant's workload in any of his or her clinical activities (although there are exceptions for consultants who previously held 1997 contracts who were allowed to keep higher ratios)
- that the volume refers to patient throughput adjusted for complexity through the medium of the Casemix system and
- that the ratio of public to private practice will be implemented through the Clinical Directorate structure and the employer has full authority to take all necessary steps to ensure that the consultant shall not exceed the agreed ratio

Section 6 of Consultants' Contract 2008 states that the consultant's reporting relationship and accountability for the discharge of his/her contract is to the Chief Executive Officer/General Manager/Master of the hospital (or other employing institution) through his/her Clinical Director. Separate arrangements apply for consultant psychiatrists, though still to the Clinical Director and Local Health Manager/Chief Executive Officer.

When the contract was agreed there was an acceptance that the Hospital Inpatient Enquiry System (HIPE) would form the basis of the monitoring mechanism for inpatient and daycase activity with further systems to be developed to measure and record other activity such as outpatient and diagnostic services.

There are a number of factors that influence the level of private activity within any given hospital. As was indicated in the section examining activity in acute hospitals in chapter 3, considerable demand in public acute hospitals arises from presentations in emergency departments and, as such, there is little that can be done currently to

70 Consultants' Contract 1997

control this activity. Other relevant matters outside of the control of the HSE were reported by the C&AG⁷¹:

- the specialities of the hospital
- whether it is a larger hospital providing emergency and complex care or it is a smaller hospital with less complex emergency, day case and elective care
- whether comparable services are available in a near-by private hospital
- where there is no private hospital located in the same region as the public hospital – all required private work must be done through the public hospital
- the various consultant contract types within the hospital
- whether consultants in the hospital hold split appointments in that they work over two or more hospital locations – a high ratio of private activity in one location may be offset by a low ratio in another location.

We asked the HSE to provide additional information in relation to oversight and monitoring of contracts including on matters relating to the processes for monitoring activity levels and measures in place to ensure compliance with contracts. The HSE responded that the review and oversight of a consultant's work practice schedule is a function of the local Clinical Director. While the basis of the review is the raw data taken from HIPE, the monitoring mechanisms need to take account of other matters such as the volume of patients and the patterns of patient attendances (e.g. elective, day, emergency). The HSE outlined a number of difficulties with monitoring compliance which included workload patterns needing to be monitored across multiple sites in circumstances where consultants work in different locations, consultants concentrating private activity in one site while still remaining within overall compliance, extracts from HIPE that are limited to particular time periods being misleading (for example in not reflecting full case complexity etc.) and pointed to the fact that the Clinical Director relies upon data only available within the hospital such as outpatient activity data, theatre schedules and individual patient data.

The HSE also indicated that the overall national private activity levels have been consistent over the last number of years, running at approximately 17% and variances at individual hospital level are explainable for reasons such as:

- the number of consultants holding pre-2008 contracts,
- historical bed designation,
- absence of private facilities in the locality and
- hospital specialisation

71 See paragraph 16.23 of Report on the Accounts of the Public Services 2017, Comptroller and Auditor General, see http://www.audgen.gov.ie/viewdoc.asp?fn=/documents/annualreports/2017/Report/EN/Report_Accounts_Public_Services_2017.pdf

However, it is clear that the HSE was unable to provide evidence that individual consultants are in compliance with contractual obligations.

The C&AG, in the Report on the Accounts of the Public Services 2017 referred to previously, made a similar observation:

For the purpose of this examination, information was requested from the HSE on individual consultant public and private activity levels for 2017. The HSE was not in a position to supply this information because it does not monitor or collate information at individual consultant level.⁷²

A court action which was settled in 2018 was taken by a group of consultants against the State for alleged breach of Consultants' Contract 2008. The State, as part of its defence strategy, examined possible non-compliance with the terms of the contract by the plaintiffs in the case (i.e. the consultants), particularly in relation to the level of private practice undertaken. In the context of the settlement of the action, the Minister has stated that eligible consultants who settle under this agreement affirm the terms of the Consultants' Contract 2008. He has explained⁷³ that the HSE can use this fact to strengthen monitoring of compliance and it sends a strong signal that there is renewed commitment by all sides to ensuring adherence to public/private practice ratios as set out in the contract.

The C&AG also referred to the report of an external reviewer engaged to examine private activity by consultants in defence of the court action. One of the objectives of the review was to estimate the level of non-compliance with contract private practice limits across the sector. Significant gaps in the returns provided by hospitals for reasons such as "no agreed activity measurement in place" and "information not being available from HIPE" were noted and this limited the extent to which conclusions could be drawn. The representativeness of the findings is uncertain given the numbers examined by the reviewer and the data challenges. Despite this, the C&AG reported that the reviewer found that in the cases where data were available, around one third of consultants were not compliant with their required private limits.

Discussion

It is clear that there are no consistent and nationally applied systems in place for measuring total activity conducted by individual consultants and therefore there are significant weaknesses in monitoring compliance with the consultant contract. As a result, no assurances can be given about contract compliance.

⁷² Ibid, page 199.

⁷³ See Parliamentary Question 174 of 21 June 2018 (27204/18) to the Minister for Health https://www.oireachtas.ie/en/debates/question/2018-06-21/174/#pq_174/#pq_174

It is acknowledged that there are significant complexities when monitoring activity based on the HIPE data also when having to take account of outpatient and diagnostic activity. It is also understood that consultants in some specialties spend more of their time on outpatient or diagnostic activities which are not as easily monitored using the data systems in place in the HSE.

Relying on national data is not an acceptable method of monitoring compliance by individual consultants with their contracts. For example, the private activity rates in some hospitals (and in one hospital group in particular) are considerably higher than the national average (see Chapter 3 and Appendix 5) and if their data were used as a starting point for an exploration of compliance, it is likely that many individual issues would require in-depth examination.

The Review Group was also told by a number of stakeholders that it was necessary to ignore monitoring of compliance of the contract due to the perverse incentives to generate income from private activity that are currently in place.

It is clear that, to date, the contract is not monitored effectively so we have no firm evidence in relation to compliance by individual consultants.

A new compliance monitoring framework, operating at both national and local levels, has now been put in place which ensures the HSE's responsibilities as employer are discharged in line with relevant legislation and contractual provisions. A new monitoring and reporting system has been agreed and the first assurance reports were due in Quarter 4 of 2018. The key elements of the assurance framework are as follows:

- allocation of responsibilities for compliance monitoring at local, hospital group and national levels
- assurance/compliance statements from individual consultants to their hospital
- monthly reporting by hospital group CEOs to the National Director for Acute Hospitals with quarterly reporting to the Deputy Director General and escalation if required
- consultant contract compliance to be included in the Audit Committee work programme
- the HSE will submit reports to the Department, initially in Q4 of 2018 and annually thereafter
- the HSE will target reviews of compliance in certain hospitals to ensure that the assurance process is operating at hospital and hospital group level

- regarding offsite private practice, the HSE will seek assurance that work plans are in place and reviewed for each consultant, and will prepare a standard format for an annual statement of compliance to be completed by consultants
- hospital groups will address areas of individual consultant non-compliance in terms of hours worked, off-site practice and public private mix, and provide assurance to the National Director, Acute Hospitals when such actions are taken. The reports to the Department referenced above will include details of actions taken in relation to individuals deemed non-compliant

We recommend that this more robust monitoring and compliance system is implemented as a matter of priority in order to ensure that the principle of equitable access for public patients is prioritised.



Implement the agreed monitoring and reporting system to robustly monitor and enforce the existing consultant contract.

New consultant appointments

To begin the process of removing private activity from public hospitals, new consultant appointments should not provide for any private practice rights in public hospitals. This means that all new consultant appointments in the HSE and in HSE-funded hospitals should be to contracts which only allow public activity in public hospitals. To clearly differentiate the new contracts from the existing nomenclature, we suggest that the new contract be called a “Sláintecare Consultant Contract”.



All new consultant appointments should be to a Sláintecare Consultant Contract, which only allows public activity in public hospitals.

The Department of Health and the HSE should commence this new appointment policy as a matter of priority. While it will be a matter for the Department and the HSE to determine the provisions of the new contract, we suggest that consideration be given to ensuring that the terms and conditions of employment are similar to that of other senior management in the public service regarding matters such as duties, roles and responsibilities, and working hours. While we would envisage the duties and responsibilities of the future contract would be somewhat similar to current contracts, the Sláintecare Consultant Contract should provide that it will be a matter for the consultant's manager and/or the hospital or hospital group management to determine how the work will be organised, in agreement with the consultant. This should include matters such as the working location and rostering, including providing for 24/7 and 7/7 rostering arrangements when necessary.

Existing consultants

As described above, over 2,500 consultants have contracts with rights to practise in a private capacity in public hospitals. Obviously, the contracts held by consultants are legally binding arrangements and it is unlikely to be permissible (or desirable) for the employer to unilaterally change the terms under which those consultants are employed without agreement from the employees affected.

The Review Group, however, would like to see all existing consultants switch from their existing contracts to the new Sláintecare Consultant Contract described above. The implementation of the new Sláintecare Consultant Contract along with an increase in capacity in the public health service, will lead to a decrease in private activity in public settings over time. We suggest that the Department and the HSE should encourage consultants to move to this new contract through the introduction of a once-off “contract change payment”.

The Review Group believes that it is appropriate to offer this incentive to existing contract-holders to encourage them to move to exclusively public contracts at the earliest opportunity.



Consultants holding 2008 (or earlier) contracts under which the consultant conducts private activity on a public hospital site should be offered a “contract change payment” to move to the new Sláintecare Consultant Contract.

This “contract change payment” for existing consultants moving to the new Sláintecare Consultant Contract should be a once-off, time-limited, non-pensionable payment and should only be offered to consultants who opt to change contracts before a defined cut off-date. It will be a matter for the Department of Health and the Department of Public Expenditure and Reform to consider an appropriate amount at which to make the offer, the appropriate cut-off date and to consider whether the offer should be higher for early adopters. Such a payment would be in consideration of any loss of earnings which may arise through this major change initiative. When implementing this recommendation, it will be essential that the needs of the patients being seen in a private capacity by consultants are managed appropriately.

Consultant Pay

A number of submissions to the Review Group consultation process argued that the removal of private practice from public hospitals would make it difficult to attract and retain highly skilled medical consultants. They pointed to the current difficulties in filling many posts. Concerns expressed included a number relating to the pay of consultants, particularly that of new entrants.

The rates of pay, allowances and other pay-related conditions for consultants employed in the HSE are set by the Department of Health and issued as the Consolidated Payscales to reflect changes as they arise. The most recent version of the Consolidated Payscales is the version issued on 28 September 2018, applicable from 1 October 2018 and available on the website of the Department of Health⁷⁴. From an examination of the salary scales, two points are particularly worth noting:

- The significant salary differential between consultants with Type A (i.e. public only contracts) and Type B, B* and C contracts (i.e. the contracts that allow private practice)
- The significantly lower starting pay and the incremental progression of new entrant consultants

The key elements of the payscales are summarised in Table 5.

74 <https://health.gov.ie/blog/publications/department-of-health-consolidated-salary-scales-with-effect-from-1-october-2018/> (accessed 24/10/2018). These scales reflect the recent legal action and the increases due on 1 October 2018 as a result of the Public Service Stability Agreement 2018 -2020

Contract Type	Consultant Clinicians appointed before 1st October 2012	Consultant Clinicians appointed from 1st October 2012	Difference
Type A	€177,827	€135,644	-€42,183
	€187,360	€141,690	-€45,670
	€197,412	€149,681	-€47,731
	€202,700	€154,033	-€48,667
	€207,986	€160,561	-€47,425
	€213,274	€166,002	-€47,272
		€172,529	
		€178,513	
		€187,788	
Type B	€164,299	€128,085	-€36,214
	€172,256	€132,620	-€39,636
	€182,425	€138,883	-€43,542
	€186,837	€142,121	-€44,716
	€191,243	€146,441	-€44,802
	€195,650	€150,769	-€44,881
		€155,121	
		€161,649	
		€168,177	
Type C	€136,389	€114,206	-€22,183
	€141,193	€117,533	-€23,660
	€151,463	€119,446	-€32,017
	€152,207	€122,146	-€30,061
	€156,783	€124,845	-€31,938
	€161,360	€128,085	-€33,275
		€132,404	
		€137,263	
		€143,202	

Table 5 - Consultant paycales

International salary comparisons

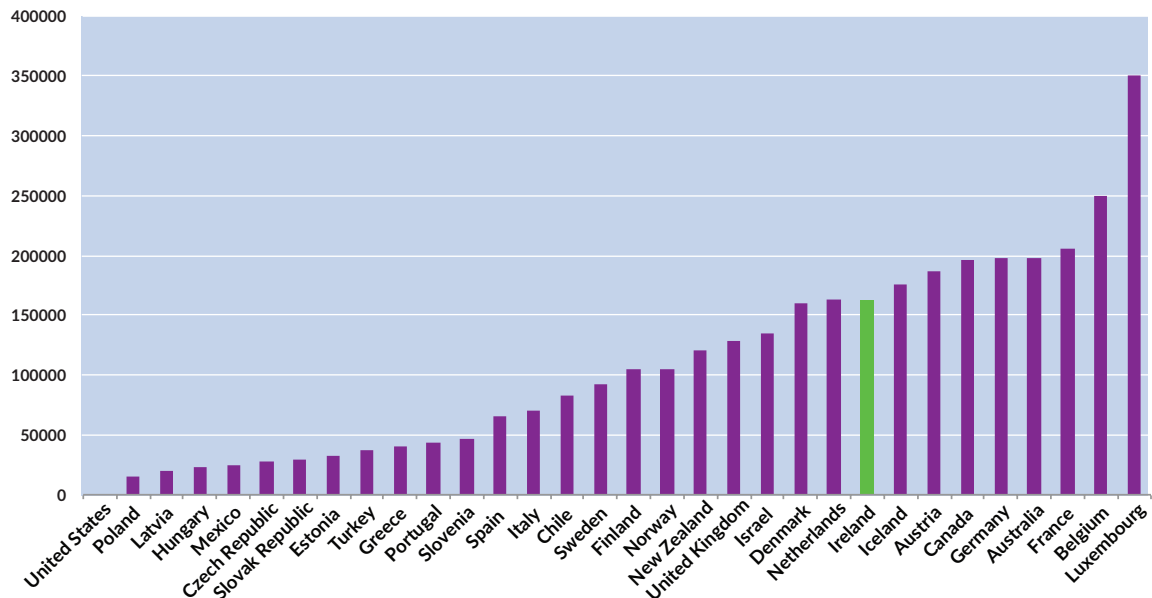


Figure 9 - Consultant pay in the OECD (Data extracted on 18 Oct 2018 15:42 UTC (GMT) from OECD.Stat)⁷⁵

As can be seen in Figure 9, the public remuneration of Irish consultants appears to compare favourably with that in other countries of the OECD although some caution should be exercised when examining the data publicly available from the OECD, including:

- The data incorporate many different types of health services – e.g. social insurance, universal health insurance, fully tax funded, publicly (e.g. tax) funded with co-payments etc.
- The data relate to “Specialists”, defined as fully-qualified physicians who have specialised and work primarily in areas other than general practice. This does not necessarily equate to an identical definition to the Irish “consultant” and varies significantly from country to country. For example, German data for “salaried physicians” reported in the specialist category includes general practitioners (as 93% of salaried physicians are specialists) but German self-employed physician data includes all physicians except general practitioners

⁷⁵ Data refer to 2017 or most recent available year. Remuneration is defined as the average gross annual income, including social security contributions and income taxes payable by the employee.

- In some countries, consultants are salaried employees, in others they are private contractors and in some countries, there is a mixture of salaried and self-employed (although whichever is the higher value is included here)
- In some countries, the reported data exclude additional allowances which are normal parts of annual remuneration. In the case of Ireland, figures exclude emergency call-out and on-call payments, except for the minimum flat annual payment, and are estimated to be from €2,430 to €22,303 per annum.
- Practice expenses are excluded for self-employed specialists
- Any supplementary income is included. For example, income from private practice for salaried physicians or salaried work for self-employed physicians is included, where known. However, in some countries, it is excluded as it is not known. This is the case for Irish data – i.e. private income for consultants working in the public service and data in respect of consultants working entirely in the private sector (approx. 600 individuals) are NOT included.
- In the case of the United States, no recent data are available (see below).

In its submission to the Public Service Pay Commission, the Irish Hospital Consultants Association drew attention to the Medscape Physician Compensation Report, a regularly conducted survey of physicians in the United States which asks about the pay and working conditions of respondent doctors. According to the most recent report, published in April 2018⁷⁶, specialist physician remuneration in the United States ranges from \$200,000 per annum (approximately €175,000) to \$500,000 (€435,000), with remuneration rates varying significantly by specialty and by geography, reflecting facts such as market conditions, business costs, competition and physician density.

However, there are a number of issues to be considered when examining consultant pay across the OECD. Primarily amongst these issues is the consideration that only a limited number of the OECD countries are relevant i.e. there is very limited, if any, movement of consultant doctors between Ireland and countries where English is not the first language. On that basis, the destinations most likely to attract Irish consultants are the United Kingdom, Australia, Canada and the United States. Table 6 sets out the relevant annual salaries.

76 Medscape Physician Compensation Report 2018, <https://www.medscape.com/slideshow/2018-compensation-overview-6009667>

Country	Average annual salary, 2017 (€)
Ireland	170,000
United Kingdom	129,000
Australia	198,000
Canada	196,000
United States	305,000

Table 6 - Remuneration with comparator countries

The median rate for US consultants is used in the table. It should also be noted that 94% of consultants employed in the Irish health service are also permitted to conduct private activity and earnings from this activity are not included in the table. It is not possible to disaggregate the average benefit to individual consultants although the total, according to the HIA (see Table 10, below) amounts to approximately €400 million per annum.

It is clear that the average remuneration of consultants for public work in Ireland lags behind that in the other competitor countries, other than the United Kingdom. However, these average figures mask a further anomaly – the pay of new entrant consultants which, of course, is the salary which will apply when attempting to attract new recruits.

Current Pay Policy

The current position in relation to pay of consultants in Ireland was set out by the Minister for Health in response to a Parliamentary Question⁷⁷ in which he indicated that the Labour Relations Commission Agreement of 7th January 2015 substantially reversed the reductions made in the pay of new entrant consultants in September 2012. Pursuant to the Agreement, the rates of pay are shown in Table 5 above.

Arising from the recent settlement of the legal proceedings by consultants in relation to pay increases provided for in the 2008 Consultants Contract, the maximum point of the scales for Type A consultants recruited prior to 1 October 2012 increases to €213,274. That increase is confined to consultants recruited prior to 1 October 2012. New entrant consultants appointed since then are not covered by the terms of the Agreement.

77 https://www.oireachtas.ie/en/debates/question/2018-07-12/449/#pq_449/#pq_449

A number of processes are currently in train that encompass consultants' pay including:

- the Public Service Stability Agreement (PSSA) provided a statutory roadmap for the unwinding of FEMPI (the Financial Emergency Measures in the Public Interest (FEMPI) Act 2015). This includes a series of salary increases that will see public servants, including consultants, receiving on average a 7% increase over the lifetime of the agreement.
- new entrant pay across the whole public service is being reviewed through a process which is being led by the Department of Public Expenditure and Reform.

The Minister for Public Expenditure and Reform recently welcomed the outcome of discussions between Public Service employers and the Public Services Committee of ICTU in respect of the 'new entrant' salary scale issue⁷⁸ in which it is reported that, in general, the agreement provides for two separate interventions which will take place at point 4 and point 8 of pay scales. The practical effect of this is that for 'new entrants' the relevant points on the pay scale will be bypassed thereby reducing the time spent (by bypassing two incremental points) on the scale for progression to the maximum point.

The particular difficulties in recruiting to consultant posts have been recognised by these new arrangements whereby incremental credit at up to the 9th point of the new entrant scale may be awarded for new appointments to consultant posts when relevant experience and qualifications are taken in to account. These arrangements are subject to a satisfactory business case being submitted in respect of the applicant concerned.

The Public Service Pay Commission (PSPC) has published its report relating to recruitment and retention issues in certain health sector grades, including consultants⁷⁹. In its report, the Commission indicated that the implementation of the settlement arising from the legal case referred to above, while necessary in and of itself, will serve to highlight further the differential in pay between the pre-existing cadre of consultants and new entrants (i.e. those appointed since 1 October 2012).

The PSPC also reported that it did not consider that recently announced measures for new entrants to other public service posts would have a similar effect in relation to consultant pay and that different policy responses would be needed to address the pay differential between existing and new-entrant consultants.

78 See Press Release available at <https://www.per.gov.ie/en/statement-by-minister-donohoe-on-new-entrant-salary-scale-issue-agreement-reached-with-public-services-committee-of-ictu/>

79 Report of the Public Service Pay Commission - Recruitment and Retention Module 1 (issues in certain health sector grades) available at https://paycommission.gov.ie/wp-content/uploads/pspc-report-2018-body_web.pdf

There is a significant gap between the pay of existing (pre 1 October 2012) and newly recruited consultants. In respect of Type A, the starting differential (i.e the difference at the first point on the scale) is €42,183, in Type B, it is €36,214 and for Type C, it is €22,183.

The two-tier pay system was identified as being one of a number of factors affecting recruitment and the Commission found that the differential in pay between pre-existing and new entrant consultants is greater than for other categories of public servants. The Commission proposed that the Parties to the Public Service Stability Agreement jointly consider what further measures could be taken, over time, to address this difficulty.

To implement the recommendation we have indicated above (namely, the recommendation relating to the new Sláintecare Consultant Contract) will obviously require a new contract to be put in place which would address the terms and conditions of employment, including salary and other allowances. While it will be a matter for the Department of Health, the Department of Public Expenditure and Reform and the HSE to engage with the representative organisations to decide on these terms and conditions, it is our view that to make the post attractive to prospective entrants and to encourage existing consultants to change to the new public-only contract, the salary differential between the suggested new public-only contract and existing contracts should reflect the fact that the terms and conditions have changed to be entirely public-service focused. Furthermore, as a first step, consideration will have to be given to removing the gap in salary between existing and newly recruited consultants.

Recruitment and Retention

Submissions from a number of stakeholders including the Irish Medical Organisation (IMO) and the Irish Hospital Consultants Association (IHCA) referred to in chapter 2 pointed to significant difficulties in the recruitment and retention of consultants. Both the IMO and the IHCA have said that the proposal to remove private activity from public hospitals will exacerbate recruitment and retention problems.

The HSE provided up-to-date information on the number of consultant vacancies in July 2018, in response to a Parliamentary Question that asked the Minister for Health to confirm ‘the number of consultant posts vacant across the State and the number of posts that are filled by locum or agency staff⁸⁰. While at any point in time there will always be vacant posts in an organisation of the size of the HSE, it is noted that this rate of unfilled posts would appear to be very high as can be seen in Table 7 and Table 8 which follow.

80 Andrew Condon, Medical Workforce Lead, Human Resources, HSE, Parliamentary Question 27854, direct response, 6 July 2018.

Unmatched Approved Consultant posts

Medical Discipline	Unmatched Consultant Posts
Anaesthesia	19
Emergency Medicine	18
Intensive Care Medicine	4
Medicine	84
Obstetrics and Gynaecology	13
Paediatrics	28
Pathology	45
Psychiatry	64
Radiology	30
Surgery	42
Unspecified	2
Total	349

Table 7 - Unmatched Approved Consultant Posts

Approved Posts filled by Agency/Locums

Medical Discipline	Nos Filled by Agency/Locum
Anaesthesia	23
Emergency Medicine	12
Intensive Care Medicine	2
Medicine	40
Obstetrics and Gynaecology	10
Paediatrics	6
Pathology	4
Psychiatry	51
Radiology	17
Surgery	25
Total	190

Table 8 - Approved Posts filled by Agency/Locums

The information above provides a snapshot of consultant vacancies at that time but there are limitations to its comprehensiveness⁸¹. In relation to posts that remain vacant, Table 7 identifies the numbers of posts that were “not matched” on Dime - this is an indicator of a vacant post. Table 8 identifies the numbers of approved posts per speciality that were filled by Agency and or Locum staff.

81 The HSE maintains the Doctors Integrated E-Management System (DIME) database. DIME is dependent on clinical sites inputting details on their consultant workforce. This database has recently been introduced and the data matching exercise is not currently 100% completed, and as such there may be variances and gaps in the data supplied to that held within hospitals. It is likely that the number of vacant posts is underreported.

The HSE informed the Review Group that of the 84 consultant posts processed by the Public Appointments Service (PAS) in 2016, 51 competitions had 2 or less applicants and in 22 cases no appointments were made⁸². The HSE also supplied the Review Group with details of the outcome of recruitment campaigns for consultant posts run for the HSE by the PAS in recent years. It is clear from the data that many difficulties are being experienced in filling consultant posts in hospitals and these are illustrated in the following Table 9 which highlights the number of consultant posts that could not be filled despite running recruitment campaigns.

Year	Campaigns Advertised	Candidates recommended	Posts advertised and not filled
2014	77	57	22
2015	141	91	61**
2016	83	80	33***
Total	301	228	116

Table 9 - HSE recruitment campaigns (excluding Psychiatry). (Source: HSE)

** 9 posts advertised twice in 2015 and unable to fill both times

*** 2 posts advertised twice in 2016 and unable to fill both times

With regard to recruitment of consultants, the Public Service Pay Commission stated that the aggregate level of vacancies for consultant posts at the end of 2017 and evidence of low level of applications for recruitment campaigns would suggest a general difficulty recruiting consultants.

The Commission also commented that it was constrained in its capacity to make definitive conclusions in respect of retention of consultants due to an absence of detailed, consistent and reliable retention data, particularly by speciality and location.

It appears that the average number of applicants for advertised posts is very low at about 2.6 applications per post but there are a considerable number of advertised posts which attracted no applicants. The HSE supplied data gathered from the Public Appointments Service which appears to indicate that the larger model 4 hospitals experience less difficulty in recruitment of consultants than the regional, smaller hospitals. We agree with the interpretation of the Public Service Pay Commission, which also analysed the data, that the relatively low level of applications (and none at all in some cases) indicates a significant on-going problem in regard to recruitment of consultants.

While there is acknowledgement that there is a general recruitment and retention

82 HSE submission to the consultation process See <https://health.gov.ie/blog/publications/independent-review-group-private-practice-in-public-hospitals/>

crisis, the severity of the issue varies geographically. When the Review Group met with senior management of the Cork University Hospital and the Mater Hospital in Dublin, neither hospital reported any major difficulties attracting consultant staff. This sentiment was echoed by officials of the Children’s Hospital Group, Dublin Midlands Group and Ireland East Hospital Group in discussions with the Review Group. It was a common position that recruitment to larger hospitals in high population areas was not a problem but that outlying hospitals experience severe problems attracting candidates for consultant posts. There is no easy answer to this problem and it raises the issue of the continued viability of some hospitals in more remote locations.

However, we have also noted that there are occasions when it appears to take inordinate lengths of time to fill posts, even in those hospitals that experience less difficulty in recruitment. It is difficult to understand how an approved post that becomes vacant through a planned exit (e.g. retirement) can take a year or longer to fill. If the post is an approved post and an impending vacancy is known, it should be a routine matter to just advertise and fill the post relatively quickly.

We understand that the Government is committed to increasing the number of consultants and to the delivery of a consultant-led service⁸³, and there are initiatives in place which attempt to address the issue, two of which are the Strategic Review of Medical Training and Career Structures (the “MacCraith Report”) and the implementation of the actions in the HSE report ‘Towards Successful Consultant Recruitment, Appointment and Retention’ summarised below.

Action on Consultant Recruitment, Appointment and Retention

In February 2017 the HSE published the ‘Towards Successful Consultant Recruitment, Appointment and Retention’ report⁸⁴. The report analysed the current operational and administrative barriers to efficient creation, approval of, and recruitment to, consultant posts. It examined the factors influencing applications for consultant posts and related workforce and service planning, delays in the application and approval process, the implementation of the Health Service Executive’s regulatory functions, the interaction between the range of agencies involved in consultant recruitment and how successful candidates are supported in the early stages of appointment. The actions to address each of these issues which are outlined in the report continue to be implemented but it is apparent that ongoing difficulties in attracting suitable candidates remain.

83 See, for example, response to Parliamentary Question 23, 19 April 2018 to the Minister for Health https://www.oireachtas.ie/en/debates/question/2018-04-19/23/#spk_313

84 <https://www.hse.ie/eng/staff/resources/hr-publications/consultantrecruitment-dec16.pdf>

The report also commented on the RCSI “Doctor Migration Project” which researched outward migration or emigration of doctors from the Irish health system. Doctors who responded to the research stated that professional rather than personal reasons were behind their decision to leave. The top 5 reasons given were working conditions, training, career progression, financial reasons and personal reasons.

Some doctors stated that the working conditions in Ireland left them with no option but to leave the State for employment elsewhere. The underlying goal was for a safe practice environment in which doctors could perform to the best of their abilities and to feel ‘pride at the end of a shift well done instead of dismay at feeling that slap-dash substandard care has been provided’.

The report noted that another key concern for many potential candidates for consultant posts has been income. Acceptance of a post is influenced by starting salary, progression through points on the salary scale, how new appointees compare to colleagues appointed in earlier years and access to private practice. As we outlined earlier, it is clear that solutions to the starting salary for new entrants to consultant posts is one of a range of measures which will be required to address the ongoing recruitment crisis.

Addressing pay-related recruitment and retention problems

The scale of the differences in starting pay for new consultants is a matter that requires action in order to remove at least one of the significant barriers to successful consultant recruitment.

It is the Review Group’s view that the starting pay for newly-appointed consultants is a significant hindrance to recruiting consultants and that these rates should be reversed to the pre-2012 levels for those doctors who take up posts under the new Sláintecare Consultant Contract. If the cuts are reversed, this would also prove attractive in encouraging existing consultants holding other contracts to switch to the new contract.



Restore pay to pre-October 2012 pay levels for all existing Type A contracts and new entrant Sláintecare Consultant Contracts.

Furthermore, and recalling that the existing pay differential between Type A and Type B or C contracts does not appear significant enough to attract consultants to take up Type A contracts as it is not perceived to offset potential earnings from private practice, it would be appropriate for the Department of Health and the Department of Public Expenditure and Reform to consider and ensure that the differential between the new Sláintecare Consultant Contract pay and existing pay rates is appropriate, and that it reflects the additional benefits to the State and to public patients using the health service.

Pay flexibility for highly specialised posts

It should also be noted that the recruitment and retention issues in Ireland are not unique and the efforts being made to ensure appropriate staffing in the Irish health service are being done against a backdrop of global shortages in health professionals and international competition for staff trained in Ireland.

We would also suggest that the Departments of Health and Public Expenditure and Reform will need to consider whether some flexibility is needed in negotiating pay for the consultant grade to recognise the particular and highly specific skills needed for certain posts. The Review Group suggests that the scheme implemented in the third level education sector by Science Foundation Ireland, which allows for recruitment of a limited number of research professors at any one time in areas of special importance, might be used as a model to address the particular challenges associated with some posts (see Appendix 8 for details of the SFI Research Professorship Programme). If a similar scheme was to be introduced in the public health service, it could be used to attract the very highest qualified candidates for particular posts. However, we would caution that the implementation of any such scheme would have to be done under very tightly controlled circumstances and only used in exceptional circumstances.



Introduce a scheme to allow a special derogation from pay caps to address recruitment to highly specialised posts.

Clinical indemnity

As part of Medical Council Registration requirements, there is a legal obligation on medical practitioners to have a minimum level of indemnity cover in place. This obligation is set out in Section 38A of the Medical Practitioner Act, 2007 (as amended).

Clinical indemnity cover in respect of clinical negligence claims occurring in public hospitals and HSE health care facilities is provided by the State's Clinical Indemnity Scheme (CIS). All consultants practising in the public system are covered by the Clinical Indemnity Scheme (CIS) and the scheme also covers consultants for their private practice in public hospitals.

The State Claims Agency has a statutory responsibility to manage claims under the CIS and in 2018, was allocated €274m by the Department of Health to manage the scheme.

Consultants working in full-time private practice and those with a contract that permits off-site private practice must purchase professional indemnity cover for this private work from medical defence organisations or from commercial insurers up to a certain levels or "Caps". Above this level, the State meets the costs of claims for adverse clinical incidents for those consultants in wholly private practice in non-public funded hospitals. This reduces the cost of clinical indemnity cover for consultants who have no public contracts.

We can conclude two main points from the Scheme as follows:

- in the case of private practice in public hospitals, the consultant is, in effect, receiving indemnity cover without cost to the individual consultant.
- in the case of capping liability in private hospitals, the cost of purchasing insurance is significantly reduced

Both of these matters are, in effect, subventions by the State which directly support private activity, reducing the net cost of that activity to the provider (i.e. the individual consultant and private hospitals) and to the purchaser (i.e. the private health insurer).

While the State has traditionally relied on the complementary nature of public and private activity by consultants, it is the Review Group's view that the clinical indemnity policy should be revisited. We suggest that the Department of Health should examine this matter with a view to ensuring that there is a level playing field in relation to the clinical indemnity between private work carried out in public and private hospitals.

Conclusion

The difficulties of recruitment and retention in Ireland are of considerable concern. While Irish pay and conditions of employment compare reasonably favourably with many other countries worldwide, there are differences in those countries which are most attractive to Irish doctors. It is also of concern that working conditions in those other countries also appear more appealing than the situation which exists in Irish hospitals. The Review Group believes the recommendations we have made relating to a new Sláintecare Consultant Contract and the proposals to make it attractive for new and existing consultants will help in addressing some of the challenges of recruitment and retention. However, much more needs to be done to improve the working conditions faced by staff working in Irish hospitals in order to make them more attractive places to work.

6. Private Health Insurance

Introduction

In this chapter, we examine the implications for private health insurance of the proposal to remove private activity from public hospitals.

Background

The market for voluntary private health insurance in Ireland is large by international comparison, with over 45% of the Irish population (2.08 million people) covered by health insurance. Extensive private voluntary health insurance has been a longstanding feature of Irish healthcare, as the chart below demonstrates. 2018 figures from the Health Insurance Authority show that private health insurance in Ireland is currently worth just over €2.5 billion (total market premium).

Under the Health Insurance Acts, Irish health insurance is a community-rated market. This means that risk is shared across the whole community of insured people, thereby ensuring solidarity with, and affordable premiums for, less healthy people and older people. (Commonly in insurance, each individual is risk rated, which means that their premium will be calculated based on their age, gender, health status and so on.)

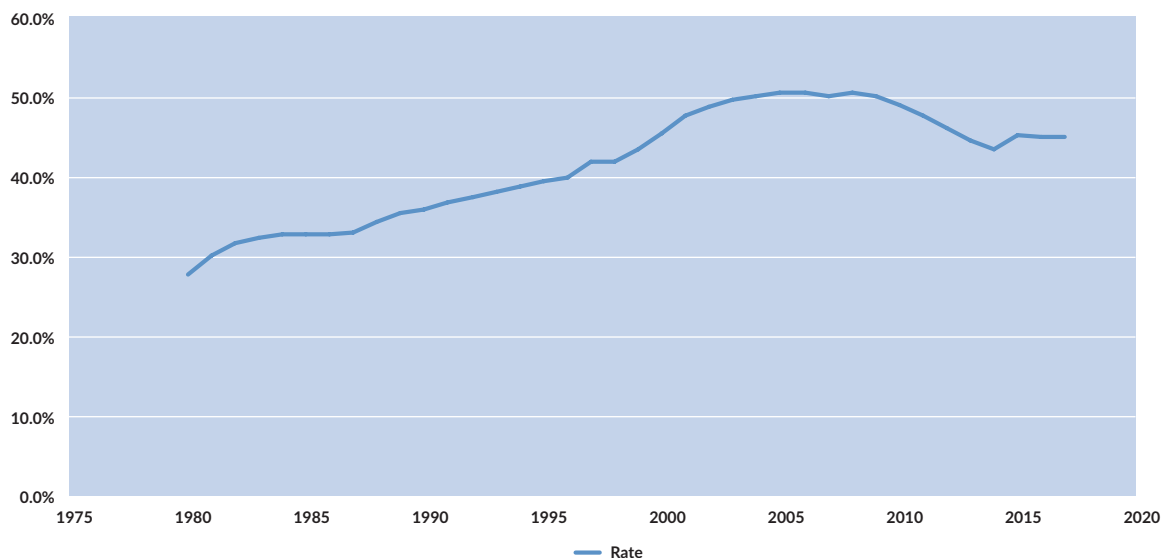


Figure 10 - Population health insurance coverage (Sources: White Paper on Health Insurance 1999, Health Insurance Authority data 2018)

Health insurance in Ireland is predominantly focused on hospital activity. As can be seen in the following table, in the 12 months to June 2018, approximately €1.9 billion was paid by insurers to cover claims costs arising in hospitals (known as “returned benefits”). Of this, 28% of the total went to public hospitals, 51% to private hospitals and 21% to medical consultants (working in public and in private hospitals). Whereas previously private care was mainly provided in public hospitals, with the expansion of the private hospital sector the majority of health insurance claims now arise in private hospitals.

	Returned Benefits (€m)			% of Total Returned Benefits		
	Year ended 30-Jun-18	Year ended 30-Jun-17	Movement	Year ended 30-Jun-18	Year ended 30-Jun-17	Movement
Public Hospital	521	593	-72	27.8	31.1	-3.3
Private Hospital	963	917	46	51.4	48.1	+3.3
Consultant	390	396	-6	20.8	20.8	+0
Total Returned Benefits	1,874	1,906	-32			
Excluded Benefits	197	189	8			
Total Benefits	2,071	2,095	-24			

Table 10 - Private Health Insurance Returned Benefits

Potential impact on Private Health Insurance

It is extremely difficult to predict with a high degree of certainty or accuracy what the full range of possible consequences for health insurance in Ireland might be if private practice is removed from public hospitals. This is because health insurance is a complex market and introducing significant change can bring numerous variables into play, whose interaction is challenging to analyse.

The Review Group heard from a range of stakeholders in the form of written submissions and in meetings regarding this issue. These stakeholders included the Health Insurance Authority (the regulatory authority for the private insurance sector), the three open market insurers, Irish academic input, opinion from international experts based abroad and other experts.

While difficult to anticipate the full impact on insurance of removing private activity from public hospitals, several predictable consequences present themselves.

Firstly, it would be fair to anticipate that the numbers buying health insurance will decrease. For a start, the 10% of total health insurance policies that are currently classified as non-advanced plans would become defunct - these are less expensive plans that mainly provide their lower level of benefit in public hospitals. (The other 90% of the market purchase what are called “advanced plans” which are more expensive policies with higher levels of cover.)

More broadly, actuarial consultants on contract to the Department of Health estimate that about 40% of the total insured population, or some 810,000 people, primarily receive their treatment in public hospitals. This cohort of insured people will be most directly affected by the change – and are the most likely to reconsider the need for health insurance, especially if public hospitals are seen to be delivering timely, quality healthcare. If this entire 40% segment of the market (810,000 people) no longer felt the need to purchase health insurance, this would leave 28% of the Irish population with health insurance cover (down from a little over 45% at present).

The second impact concerns the cost of health insurance for those who continue to purchase policies. There could be two effects here. In the short term, there would very likely be price reductions in the cost of health insurance, especially as the market found a new equilibrium. The removal of privately-funded medicine in public hospitals would mean that insurers would no longer be paying for €524 million worth of activity (2018 figure), nor paying €140 million in private fees to medical consultants employed by the HSE (estimate provided by one insurer). Clearly, there would at the same time be a significant fall-off in premium income to insurers. To provide context for this, the average gross premium paid by consumers, before tax relief, was €1,214 in 2018.

Over time, however, the cost of health insurance for those who maintain their cover may rise. The Department of Health’s actuarial consultants looked at five hypothetical scenarios where, post-removal of private activity from public hospitals, different proportions of the current market are projected to drop their insurance:

- in three scenarios there could be a cost increase of between 1% and 7%;
- there could be a marginal 1% fall in the cost of health insurance in one scenario (where the 40% who primarily receive their private healthcare in public hospitals decide to quit the market);
- while in the most extreme scenario, where three quarters of the entire insured population exit the market, including because of the excellent standard of public healthcare, the cost of health insurance for the remaining minority could rise by one-third.

A further impact on health insurance of removing private medicine from public hospitals is a pronounced regional effect in policyholders who would likely decide to leave the market. Instead of being uniform across the country, any shrinking in the size of the insurance market is likely to be disproportionately evident in locations with few or no private hospitals, such as the midlands or the north-west of Ireland (there are private hospitals in 10 counties: Cork, Dublin, Galway, Kerry, Kildare, Kilkenny, Limerick, Sligo, Waterford and Westmeath).

It is also very likely that if the health insurance market does shrink because of the removal of private practice from public hospitals, then the market will also age. It can be anticipated that those more concerned about their health and their healthcare – older people and less healthy people – will be more likely to retain their insurance cover, compared to younger people or healthier people. A change in the demographic balance in the market would have implications both for the cost of premiums and for the level of the stamp duty⁸⁵ levy to sustain a community-rated market. Indeed, more broadly, and not connected with the removal of private care from public hospitals, in the coming decade health insurance - in line with healthcare overall – may well see significant increases in cost due to our ageing population and predicted claims inflation.

The removal of private practice from public hospitals, together with successful implementation of the suite of Sláintecare reforms – most notably significant reduction in waiting times for elective care – will have a direct impact on demand for health insurance. Successful Sláintecare reforms would reduce the size of the market and, ultimately lead to a change in the nature of health insurance to a more supplementary role over time. The Health Insurance Authority notes that while “it is impossible to predict just how big that health insurance market would be” post-removal of private practice from public hospitals, the most important factor in shaping the market would be “how big an increase in financial and human resources would be devoted by the State to the public health system”.

The risk of a shock to the health insurance market with the removal of private practice from public hospitals should be mitigated by the progressive and phased approach recommended for the removal of private practice. This approach lets demand for health insurance decline naturally in response to improvements in public care.

85 Health insurers receive risk equalisation credits to compensate for the additional cost of insuring older and less healthy members. The credits are funded by stamp duty levies paid by insurers for each insured life covered. All of the money collected in stamp duty is paid into the Risk Equalisation Fund and redistributed among insurers in the form of risk equalisation credits. The Risk Equalisation Fund is managed by the Health Insurance Authority.

7. Finances

Introduction

In this chapter, we examine the financial implications of the proposal to remove private activity from public hospitals.

Background

The Sláintecare Report concluded that the setting of targets for the level of private income for public hospitals created a perverse incentive for the managers of public hospitals. The report recommended the phasing out of charges over a 5 year period and replacing the income by additional public funding amounting to an estimated €626 million (2016 figure).

In 2016, private patient income peaked at €626 million and amounted to 12% of public hospital expenditure. Private patient income is now falling, down to €570 million in 2017 and is estimated to have fallen further to approximately €524 million in 2018. This fall in income is likely due to two main reasons. First, the private health insurers have been running a campaign to encourage their customers not to use their insurance when they are admitted to a public hospital through an Emergency Department (insurers argue that their customers' treatment and accommodation is the same as that of public patients). Second, admissions through Emergency Departments continue to rise, most of which are public patients. Hospitals and hospital group management report that private income is continuing to fall and they expect this trend to continue for the foreseeable future.

As described in chapter 3, public hospitals are obliged to charge statutory fees of up to €80 per night (up to a maximum of €800 per annum) for each patient in receipt of public inpatient services, up to €1,000 per night for private inpatient charges and €407 for day cases where overnight service is not provided.

The Department of Health provided the Review Group with figures relating to the income derived from the private patient maintenance charges by hospital. Private patient income, both in real terms and as a proportion of overall income, varies considerably across individual hospitals and across hospital groups. The actual private patient income, by hospital group, is presented in Table 11 which follows.

	2013	2014	2015	2016	2017
	'000	'000	'000	'000	'000
RCSI	62,599	78,845	83,388	82,325	73,555
Dublin Midlands	99,418	118,431	124,868	126,139	113,786
Ireland East	76,845	99,299	109,022	109,832	99,986
South/Southwest	100,945	122,205	137,191	143,629	127,705
Saolta	61,644	77,036	74,486	77,582	75,358
University Limerick	45,122	50,545	60,910	62,273	60,267
Children's Hospitals	20,829	23,738	25,961	24,493	20,161
Total	467,402	570,099	615,826	626,273	570,818

Table 11 - Private Patient Income by Hospital Group 2013 – 2017
(Source: Department of Health)

As a percentage of overall income, private patient income ranges from 9% in the Children's' Hospitals Group to 18% in the University of Limerick Hospital Group and from negligible up to 23% in individual hospitals.

The scale of private patient income in individual hospitals is a function of the *type* of activity in the hospital rather than the number of discharges. For example, hospitals with more day case activity receive lower income per capita but may discharge more private patients than hospitals with small numbers of overnight inpatient activity. Income is dependent on the number of bed days per private patient in the hospital and this is going to vary considerably particularly as the hospital groups evolve through measures such as more efficient use being made of particular hospitals for certain types of activity.

Clinical indemnity

As was described earlier, the Review Group believes that the State provides a subvention in respect of clinical indemnity for the private activity of consultants. It is not possible to estimate how much that subvention is worth, but clearly it will need to be considered in the context of future financial arrangements relating to removing private activity from public hospitals.

Capacity

We have examined the argument that removing private activity from public hospitals would increase capacity for public patients. There are at least two main inputs required to maintain the current overall level of delivery of acute services following the removal of private practice from the public system (when private patients will be replaced by, or themselves become, public patients). First, replacing the services currently provided on a fee-for-service basis by private contractor consultants with public consultants and, second, funding this activity and replacing the private patient income that currently makes a very significant contribution towards the cost of delivering the service. In effect, while no additional capacity is created by removing private activity, existing capacity – in the form of infrastructure, staffing, facilities and so on - can be used to maintain the overall level of service, subject to replacing privately-acting consultants with public consultants and funding the actual activity.

Consultant Pay for new appointments

The most obvious cost associated with removing private activity from public hospitals is to ensure that adequate numbers of consultants are engaged on public-only contracts and that this number increases over time.

As described earlier, in the year ending August 2018, the HSE appointed just 118 consultants. The pay bill associated with those appointments, most of which were appointments to existing posts, would be approximately €15 million at current Type B contract rates. The same rate of recruitment to the new Sláintecare Consultant Contract would cost €21 million. In other words, the *additional* cost of appointments on the salary scale we have proposed instead would be about €6 million. Importantly, it should be noted that consultants appointed to the new contract would, on average, be delivering significantly more public activity per capita than they would under previous arrangements (i.e. they would not be permitted to deliver up to 20% of their activity in a private capacity).

The HSE needs to recruit greater numbers of consultants, both to address existing vacant consultant posts and to move closer to the desired number of consultants in the public hospital system. At just 118 in the year to end August 2018 or on average about 100 per annum over the last five years, the Review Group has serious concerns that not enough is being done to ensure that sufficient numbers of consultants are being recruited simply to replace those that are retiring. The proposals we have made will address some of the concerns relating to recruitment and retention. That said, our proposals are not intended on their own to solve the recruitment challenges faced by the HSE which require a concerted effort by all concerned to ensure that an adequate number of consultants are employed in our public hospitals.

As described earlier, 27% of consultants are due to retire over the next 10 years. Incentivising consultants to change to the new contract we have proposed will have pension implications.

Table 12, below, gives an indication of the approximate additional annual costs of employing consultants on the Sláintecare Consultant Contract (to conduct exclusively public work in public hospitals):

Recruitment numbers	Type B pay cost € (m)	Sláintecare Consultant Contract Cost € (m)	Additional Cost € (m)
118	15.1	20.9	5.8
250	32	44.4	12.4
300	38.4	53.3	14.9
1000	128.4	177	48.6

Table 12 - Estimated additional costs of employing consultants on new contract

Contract Change Payment for existing consultants

The Review Group understands that the private income earned by consultants is not evenly distributed among all consultants. A contract change payment would act as an incentive to encourage as many consultants as possible to change from their existing contract to the proposed new Sláintecare Consultant Contract. It will be a matter for the Department of Health and the Department of Public Expenditure and Reform to consider the appropriate amount at which to set the contract change payment to attract as many consultants as possible. As a once-off payment to individual consultants, the cost will only arise during the period when the payment is offered. It should only be offered to consultants who opt to change contracts before a defined cut off-date, and should not be on offer indefinitely.

Cost of increases in public activity

There are two important points on how to go about removing private activity from public hospitals and increase public activity. First, ceasing private activity in public hospitals overnight or within a very short timeframe would simply increase public waiting lists, without providing a solution for services to respond to the increased demand. That is why it is necessary to phase in the removal of private activity through the changes we have indicated relating to the new Sláintecare Consultant Contract – over time, increased numbers of public consultants will deliver an increasing amount of public activity. Secondly, there needs to be a clear timeframe within which a transition to exclusively public activity in public hospitals is completed, with a deadline after which all private activity has been discontinued. Dragging on a transition

process indefinitely would only postpone and undermine achievement of the defined objectives and benefits of a public hospital system providing treatment exclusively for public patients.

It is difficult to predict the scale of increase in public activity that will accompany a decrease in private activity, particularly in the short term. It would be reasonable to assume that over the lifetime of Sláintecare, public acute hospitals will be better equipped and resourced to respond to the increasing demand placed upon them. It is also difficult to predict what type of activity is most likely to immediately change from private to public although it can be anticipated that some specialties will probably be more affected than others, at least in the short term. Finally, there are particular challenges in relation to estimating changes in outpatient activity in a phased transition to the removal of private practice. This is due to the fact that no data exist relating to private outpatient activity currently conducted by public consultants with Type B, B*, C or 1997 contracts, so it is difficult to estimate how much additional public demand will arise should fewer consultants with those rights be available to conduct private activity.

The cost of providing public activity will ultimately be managed within the Activity Based Funding model (see Appendix 1 for definition) and the block grant arrangements already in existence in the public hospital service. The increase in public activity caused by a switch from private activity will increase the overall costs of providing public hospital services. Given that the removal of private activity from public settings should happen incrementally, two potential scenarios are illustrated although each has similar long-term cost implications:

1. Private activity reduces on an annual basis e.g. by (a) 10% or (b) 20% per annum, and is time-limited, with a deadline beyond which no private activity will be allowed. See scenario 1(a), a 10% annual decrease in private activity replaced by equivalent public activity, and 1(b), a 20% annual decrease in private activity replaced by equivalent public activity, in the table below.
2. The reduction in private activity is based on demand with the consultant contract used as the driver and is time-limited, again with a deadline beyond which no private activity will be allowed. In this scenario, it is likely that public activity will increase over time but the rate is uncertain. Initially, when consultants are appointed on public-only contracts, there is a marginal per-capita increase in public activity. If this is estimated to be 10%, the overall scenario is identical to scenario 1(a) above.

A further option based on a reduction in private activity and increase in public activity using the consultant contract as the driver of change but not time-limited and instead open-ended is also possible. This scenario would be somewhat similar to scenario 2

above but would extend out indefinitely. It should be noted that this scenario does not meet with the timeframe the Review Group has recommended earlier for the complete removal of private activity from public hospitals. The Review Group has concerns that allowing the process to drag on indefinitely will not achieve the defined objectives and it would be likely to take more than thirty years to fully achieve a public hospital system exclusively providing public services. This scenario is not mapped out below.

Of the scenarios outlined, 1(b), with an annual decrease of 20% of private activity during a five year transition period, would achieve the removal of private activity within five years and the full year costs at the end would be as indicated in the table.

It should be noted that using percentage increases to predict the likely impact of removing private impact has some drawbacks. The actual annual increase in public activity is difficult to predict accurately as such an increase will be influenced by which patients choose to remain in public hospitals when alternative services might be available in private hospitals, or which consultants are available to provide a public, rather than a private, service in the public hospital setting. The ultimate additional annual cost of providing the public service after complete transition to an exclusively public system is the same in each scenario but with differing residual amounts in the final year depending on the length of the transition period.

By way of explanation of the calculations in the table below, according to the HSE, the average daily running cost of an inpatient hospital bed is €856⁸⁶. This cost includes all clinical and non-clinical staffing, theatre and laboratories, cleaning and maintenance costs and running costs such as heating and lighting. It excludes capital and depreciation and does not include other costs of running an acute hospital such as day case activity, outpatient and Emergency Department costs. The cost is a national average so all different types of activity carried out in public acute hospitals is included in calculating the national average and this ranges from very simple, routine and inexpensive activity, to the most complex and expensive. According to HIPE, the average length of stay for inpatient activity has remained consistent for inpatient activity over the last number of years at 5.7 days which is used in the following calculations. The equivalent cost used for the daycase activity calculations is €407 with an average length of stay of 1 in the following calculations.

86 Direct response by HSE to Parliamentary Questions 44993/18 and PQ 45116/18 of 6 November 2018

Scenario	Year 1	Year 2	Year 3	Year 4	Year 5	Residual activity and cost	Total
1(a) 10% p.a.							
Private discharges	238,019	211,573	185,126	158,680	132,233		
Increase in public discharges	26,447	26,447	26,447	26,447	26,447	132,233	
Cost	61,576,455	61,576,455	61,576,455	61,576,455	61,576,455	307,882,277	615,764,554
1(b) 20% p.a.							
Private discharges	211,573	158,680	105,786	52,893			
Increase in public discharges	52,893	52,893	52,893	52,893	52,893		
Cost	123,152,911	123,152,911	123,152,911	123,152,911	123,152,911		615,764,554
2							
Private discharges	238,019	211,573	185,126	158,680	132,233		
Increase in public discharges	26,447	26,447	26,447	26,447	26,447	132,233	615,764,554
Cost	61,576,455	61,576,455	61,576,455	61,576,455	61,576,455	307,882,277	

Table 13 - Costs of replacing private activity with public activity

In summary, the total cost of replacing private activity by public activity is €616 million. The annual cost depends on the time period over which this is phased⁸⁷.

Income which will arise with the removal of private activity

As was argued earlier, it is likely that most of the private activity which is conducted in public hospitals will remain within the public hospital system due to its nature. The activity which remains would therefore become liable for the public patient statutory charges.

⁸⁷ It should be noted that there are limitations in this calculation as the HSE's activity based funding model is in operation in respect of inpatient and daycase services only and private activity in public hospitals includes discharges which originated in Emergency Departments. The private activity used in the table is based on 2017 activity data from HIPE which reported 264,466 discharges composed of 113,619 inpatient and 150,847 daycase discharges.

The daily inpatient charge for public patients who do not have medical cards is €80 (up to a maximum of €800 in one 12 month period) and average length of stay for inpatient activity of 5.7 days with maternity services exempt from charges. Assuming all the current private activity changes to public activity, the following table sets out the additional maximum income arising under the existing eligibility rules.

Activity type	Rate	Approximate Discharges	Average length of stay	Total income
Day	80	140,000	1	11,200,000
Inpatient	80	90,000	5.7	41,040,000
Total		230,000		52,240,000

Table 14 - Statutory public charges raised through increased public activity

It should be noted that this assumption is a maximum calculation as some of those who have private health insurance also have a medical card and would therefore, not be liable to pay the public patient charge. While the maximum amount that could be raised if all private activity becomes public activity is €52 million, the Review Group estimates that the actual amount is likely to be less than this because some private patients have medical cards and we have therefore included a conservative figure of €40 million under this heading. It should also be noted that during the initial stages of increased public activity, the actual amount will be quite low but will rise over time.

Tax Relief on health insurance

At present, tax relief on medical insurance is provided at the standard rate limited to the cost of the policy up to a maximum of €1,000 per adult (i.e. a credit of up to €200 is applied) or €500 per child (equal to a credit of up to €100)⁸⁸. According to the Revenue Commissioners, in 2016 tax relief of €329 million arose in respect of medical insurance⁸⁹. This relief was awarded in respect of total gross health insurance premium income in 2016 of €2.53 billion.

As private activity in public hospitals reduces with a consequent rise in public activity, there are likely to be two effects. First, the overall value of insurance claims will reduce and the cost of insurance premiums should fall, particularly in the early years. Secondly, fewer people will decide to purchase private health insurance. Therefore, there will be savings in the cost of tax relief that will arise as private activity is removed. By way of example, a single year reduction of approximately €500 million in health insurance expenditure would reduce tax relief by €65.8 million in that year.

While it is difficult to calculate exactly how much will be saved by the State in reduced tax relief, it is clear that the amount will be significant as less is spent on health insurance.

⁸⁸ See <https://www.revenue.ie/en/personal-tax-credits-reliefs-and-exemptions/health-and-age/medical-insurance-premiums/index.aspx>

⁸⁹ See Costs of tax expenditures (credits, allowances and reliefs) available on the website of the Revenue Commissioners at <https://www.revenue.ie/en/corporate/information-about-revenue/statistics/tax-expenditures/costs-expenditures.aspx> (accessed 16 January 2019)

As can be seen in the section on the impacts on the private health insurance market in Chapter 6, about 40% of the total insured population, or some 810,000 people, primarily receive their private insurance benefits and treatment in public hospitals. If all of those policy-holders decided not to continue their health insurance, the tax relief foregone would amount to a maximum of approximately €131 million. For example, those who hold health insurance policies that are currently classified as non-advanced plans (approximately 10% of the market) do not receive the full tax relief of €200 as the policies cost less than €1,000. However, it would also be reasonable to assume that some people holding advanced plans who are currently primarily availing of services in private settings would also be encouraged to discontinue their private health insurance as public services improve.

Should the 40% of the insured population currently receiving their private insurance benefits and treatment in public hospitals decide not to renew their policies incrementally over the first number of years of the transition as public services improve, then by the time private activity is entirely removed from public hospitals, an approximate saving of up to €131 million per annum in tax relief will have been made.

Options for funding increased public activity

There are a number of options that the Department of Health and the Department of Public Expenditure and Reform could consider to fund the additional costs arising from the increased levels of public activity which are going to arise under this proposal. It is clear that there are two main options: either increase the statutory public charges for all users of public hospital services or, alternatively, provide more public funding as needed. In relation to the former option, Sláintecare was clear in recommending a reduction in charges for public health services rather than an increase. Furthermore, the scale of increase in charges per user would be so large that it would make the health service inaccessible for huge numbers of people. For example, the current €80 per night charge for a public patient would need to rise to over €500 for every patient using public services. This would not be an acceptable solution.

Therefore, it is the Review Group's recommendation that this funding will have to be provided from the Exchequer through the annual Estimates process. It is obviously a matter for the Government to decide how to raise the necessary funds for this increase in expenditure. For example, using taxation as an approach, to give an indication of the increases which might be required:

- An increase of 1% in the top rate of income tax would yield € 347 million
- A 1 % increase in the standard rate of VAT (now 23 %) would yield €463 million
- A 10 cent increase in the tax on petrol and diesel would yield €363 million.

However, it is absolutely clear that any increase in taxation at individual level would be significantly offset by a reduction in the cost of medical insurance for policyholders.

Summary of the cost impact of removing private activity from public hospitals

The following table sets out the probable final cost impact when private activity no longer occurs in public hospitals. A number of assumptions are made in this calculation as follows:

- Although some private activity will be displaced to the private hospital system, the calculation is made on the basis that all private activity is going to become public activity
- Case complexity between private and public activity and average length of stay are assumed to be similar
- The bed cost per night used in the calculation is an average across all public hospitals and all services
- It was beyond the scope of this analysis to identify how many additional consultants are needed in the public health service. By the time full removal is achieved, the Review Group estimates that an additional 1,000 consultants will have to be recruited to the new Sláintecare Consultant Contract to ensure adequate replacement of retiring consultants
- The Review Group expects a significant number of existing consultants to transfer to the new contract although there is no way of knowing how many. In the calculations, we have assumed that half will transfer
- As stated earlier, the Review Group has not recommended what the value of the proposed contract change payment should be and no amount is included here so that it will not be taken to be indicative of a recommendation. However, it should be a once-off payment (although the expenditure will arise over a number of years depending on the uptake by existing consultants)
- No increase in public statutory charges is envisaged
- Capacity to provide the service is available
- Calculations are based on current activity although increased demand for public services is going to arise due to demographics, rising rates of chronic disease, etc. These matters are assumed to be addressed adequately in the implementation of the Capacity Review and wider Sláintecare reform programme
- Potential impact of inflation is not included
- Reduced tax relief is included in funding additional expenditure
- This is a final year calculation. It should be noted that the increase in expenditure will arise as soon as implementation of the recommendations in this report are

commenced. Initially the annual increase will be low (primarily driven by the new consultant contract and small increases in public activity)

- The calculation includes an estimate of the cost of consultants holding 2008 or earlier contracts who will change to the new contract. While the Review Group hopes that all consultants will choose to change contracts, we understand that some may chose not to, although it should be borne in mind that the legislative proposal we have suggested will clearly signal, in advance, an end to private activity

	'000,000
Expenditure	
Increased activity	616
New consultant contracts	48.6
2008 or earlier moving to new contracts	35
Total expenditure	699.6
Income	
Increased numbers liable for public charges	40
Total income	40
Annual cost of removal of private activity	659.6

Table 15 - Annual Cost of removing private activity from public hospitals

This amount of €659.6 million is the additional annual cost that will arise when all private activity occurring in public hospitals no longer occurs and is replaced with an equivalent level of public activity. It should be noted that the reduction in tax relief of approximately €131 million per annum estimated above means that the net cost to the Exchequer of the increase in public activity is €528.6 million. It is likely that the numbers of people holding private health insurance will reduce further as public hospital services improve and the savings in tax relief will continue to grow.

8. Transitioning to full implementation

Introduction

In this section, we examine some of the feasible options for the transition towards the removal of private activity from public hospitals.

Alternative Options

The parameters of how to go about removing private practice from public hospitals emerge from consideration of the alternative options in turn.

A “big bang” approach of ceasing private activity in public hospitals overnight or within a very short timeframe would bring the very real risk of simply increasing public waiting lists, without providing a solution in terms of services to respond to the increased demand. The Sláintecare Report makes multiple references to the phased elimination of private care from public acute hospitals over a period of five years.

A progressive or phased removal of private activity, on the other hand, is the single most important step in recognising the complexity of this policy change. By allowing the flexibility and time to make adjustments during the period of transition, the Government can mitigate the risks of any unforeseen consequences in its implementation.

However, it is also important to have a clear timeframe within which a transition to exclusively public activity in public hospitals is completed, and a deadline after which all private activity is not permitted. This will ensure the achievement of the defined objectives and benefits of a public hospital system providing treatment exclusively for public patients over the lifetime of the Sláintecare implementation period.

The fulcrum of change in moving to exclusively treating public patients in public hospitals will be the introduction of the new Sláintecare Consultant Contract for new appointments, encouragement of existing consultants to switch to this new contract and increased public funding to pay for the increase in public activity. This has important implications in influencing (and even dictating) how change can be effected, and in particular the need for a universal approach to application.

Because the same consultant contract applies to all consultant specialities, the feasibility of making an incremental transition on the basis of a small number of consultant specialities followed by other specialities is not established. Nor is it feasible to pilot change by offering a new enhanced contract to consultants who only work, or are starting work, at one particular hospital, or at a small number of hospitals, or in one particular hospital group.

Two crucial questions present themselves:

1. How can the transition period be limited in duration and not open-ended?
2. What the desirable length of the transition period should be?

As part of the broader package of legislative reform envisaged under Sláintecare, and in order to realise the vision of a public hospital system exclusively for public patients, it is the Review Group's recommendation that the Government should legislate for the introduction of a regime at a future date whereby private activity will no longer be permitted in public hospitals.

As regards the duration of a transition period, as noted above the Committee on the Future of Healthcare proposed the phased elimination of private care from public acute hospitals over a period of five years, and specifically between Year 2 and Year 6 of the ten-year implementation timeframe.

The Review Group considers that immediate, proactive steps to remove private practice should commence as a matter of priority, including commencement of appointments to the new Sláintecare Consultant Contract and offering existing consultants a contract change payment to move to the new contract.

However, given existing capacity constraints, it is unlikely that the complete removal of private activity is possible within the coming five years. Should this happen, a likely outcome could be significant increases in public waiting lists and damage to the prospect of achieving full removal.

Instead, allowing time for a range of Sláintecare reforms to take effect, and for increased numbers of public consultants to deliver an increasing amount of public activity, would significantly boost the chances of a successful transition to an exclusively public system. Such changes include the expansion of adequate capacity to deal with current demand and demand growth over the next five years, action on reduction of current public waiting lists to acceptable waiting times, reform to primary, diagnostic and community services and, crucially, a step-change increase in the recruitment of public-only consultants.

We recommend that the proactive removal of private practice in public hospitals takes place over the lifetime of the Sláintecare implementation timeframe. However, it is imperative that significant changes take place early on, including the introduction of legislation and the immediate introduction of the new Sláintecare Consultant Contract for new appointments.

Timeline for action

- Introduce legislation to ensure that public hospitals are exclusively used for the treatment of public patients from the conclusion of the ten-year Sláintecare implementation period.
- All new consultant appointments to be made to the new Sláintecare Consultant Contract which allows public work only in public hospitals.
- Restore pay to pre October 2012 pay levels for all existing Type A contracts and for all new entrant Sláintecare Consultant Contracts.
- Consultants holding 2008 (or earlier) contracts under which the consultant conducts private activity on a public hospital site should be offered a “contract change payment” to move to the new Sláintecare Consultant Contract.
- To mitigate the risk to specialist services, introduce a scheme to allow pay flexibility for a small number of highly specialised posts.
- Prioritise a number of crucial changes upon which success depends, including: increase hospital capacity, improve care pathways, introduce new models of service delivery, improve capacity in primary and community care, and move away from the hospital-centric model which currently exists.

9. Conclusions

Introduction

During the examination of private activity in public hospitals, we came to a number of conclusions about how the public system manages and delivers acute hospital services for private patients. The following is a summary.

The existing nature, level and role of private practice in public hospitals

- The public hospital system experiences very high demand. It is clear that existing capacity is not sufficient to meet this demand.
- While the shift towards providing more care in non-acute settings is an essential building block for the future of the health service, capacity increases in acute settings are badly needed.
- The level of private activity varies considerably by hospital and by hospital group.
- The rate of private activity in public hospitals has been falling consistently over recent years due to insurer campaigns encouraging customers to refrain from using their insurance when presenting at an ED and general increases in ED presentations.
- Removal of private activity is unlikely to generate significant additional capacity in the short term as much activity will remain in public hospitals (originating from EDs, maternity, no access to alternative services in private hospitals, and consultant availability).
- The implementation of the findings of the Health Service Capacity Review 2018 provides opportunity for all work to be public work with no necessity for private practice in public hospitals.
- The evidence is inconclusive as to the degree to which the private hospital system has capacity to deliver additional services in the short term.

The negative and positive aspects of private practice in public hospitals, including as regards access to healthcare, equity and the operation of public hospitals

- The public health service has a significant reliance on private healthcare (in public and in private hospitals) although allowing private activity uses considerable public resources to the advantage of those patients who can afford to pay privately rather than public patients.
- There are very long waiting lists for public services, and ability to pay appears

to allow people to be seen more quickly. Faster access on the part of those with health insurance appears to be secured primarily through quicker initial (private) consultation with a consultant, faster access to diagnostics and faster access to elective care.

- Current income from private activity is approximately €524 million (2018).
- Hospitals have a reliance on the income from private activity and try to maximise the collection of this income in order to balance budgets.
- Hospitals are also much more inclined to offer Type B contracts rather than Type A as they are more likely to get applicants for vacant consultant posts.
- Just 6% of current consultants are engaged on public-only contracts.
- Contracts with private practice rights have not been managed as well as they should have been.
- There are major problems with the recruitment of consultants, particularly in smaller hospitals but also there are inefficiencies in general recruitment processes.

Practical approaches that might be taken to the removal of private practice from public hospitals, including timeframe and phasing

- The Government should send a clear signal through legislation that, from a specific date in the future, no private activity in public hospitals will be permitted. Underpinning this policy by legislation will ensure that public resources are used to deliver public services.
- A transitioned approach to removal of private activity is needed although the new Sláintecare Consultant Contract can be introduced immediately.
- All future consultant appointments should be made to the new Sláintecare Consultant Contract which allows public work only in public hospitals.
- To incentivise appointments, the Review Group recommends restoration to pre Oct 2012 pay levels for all existing Type A contracts and new entrant Sláintecare Consultant Contracts.
- Future pay scales for the Sláintecare Consultant Contract should be at a level to be attractive to potential applicants for posts.
- A “contract change payment” should be initiated to encourage existing consultants to move to the Sláintecare Consultant Contract. This would be a once-off, time limited, non-pensionable payment. Such a payment would be in consideration of any loss of earnings which may arise through this major change initiative.
- Pay flexibility may be needed in a small number of cases to ensure highly / rare

- skilled positions are filled (similar to the scheme in the education sector).
- The Review Group also suggests that the Department of Health examines the Clinical Indemnity Scheme with a view to ensuring there is a level playing field between consultants with private activity in public sites with those consultants practising offsite.
 - The Review Group is not proposing any changes to statutory charging, but has noted that the additional public activity which will happen if private activity is no longer occurring in public hospitals will generate additional statutory public charges of up to €52 million.
 - Success will be dependent on a number of other Sláintecare reforms which must be prioritised – for example, increased capacity in acute settings, improved care pathways, new models of service delivery, improvements in primary and community care settings and a move away from the hospital-centric model which currently exists in Ireland.

Possible impacts, both direct and indirect, immediate and over time, of removing private practice from public hospitals, including but not limited to impacts on: access; hospital activity (including specialist services); funding; recruitment and retention of personnel; and any legal or legislative issues that might arise

- Access to public hospitals for public patients will improve over time although it will take time to recruit a larger public-focused consultant workforce and to enhance capacity.
- In the medium term, as capacity is provided and as the public-only consultant workforce grows, access will get better for public patients.
- In the shorter term, some private patients will seek treatment in private hospitals rather than in public hospitals. However, this is likely to be a small proportion of the total numbers currently.
- The additional public demand created by removing private activity from public hospitals should be funded by the Exchequer. The Government will have to decide how to raise the funding required.
- The Review Group welcomes proposals that will give HIQA additional functions in relation to patient safety and hospital licensing that will ensure the delivery of safe, quality and patient-centred care for all patients, whether accessing services in public or private hospitals.
- In the short term, private health insurance premium costs are likely to fall below what they might otherwise have been (and cost of tax relief will also fall).

- The longer term insurance picture is somewhat unclear although there is likely to be a reduction in the size of the market and simultaneous cost increases for those choosing to retain health insurance, particularly as younger people drop out leading to an increase in average age of those with insurance.

The Review Group believes that the long term removal of private activity from public hospitals can be commenced through immediate action on the consultant contract in parallel with capacity enhancements and increased funding for the expected increase in public activity. This approach would also minimise the cost implications over a long period of time.

Appendices

Appendix 1 Definitions

Types of activity	
Inpatient	Patient admitted to hospital for treatment or investigation and scheduled to stay for at least one night in hospital.
Day case	Patient admitted for a medical procedure or surgery in the morning and discharged before the evening.
Emergency department attendances	Unplanned visit by a patient for treatment. Such attendances may be upon request from a GP. Attendance in some cases may lead to a patient being admitted to hospital as an inpatient.
Outpatient attendances	A patient attends a consultant or a member of the consultant's surgical or medical team as a result of a referral. Such attendance takes place in a clinic.

Table 16 Activity definitions

Private activity

In this report, private activity is defined in the same way as used in the Hospital In-Patient Enquiry Scheme (HIPE) collected by the HSE's Healthcare Pricing Office (HPO). According to the HIPE definition, the Public / Private status of the patient refers to whether the patient is treated on a private or public basis rather than the type of bed occupied or whether the person has health insurance or not (i.e. patients may be paying directly for services.)

Consultant

For the purposes of this report, a consultant is defined in the same way as defined in section 10 of the Consultants' Contract 2008 i.e. a consultant is a registered medical or dental practitioner who by reason of his/her training, skill and expertise in a designated specialty, is consulted by other registered medical practitioners and who has a continuing clinical and professional responsibility for patients under his/her care, or that aspect of care on which (s)he has been consulted. It should be noted that in a number of instances in this report, the singular word "consultant" is used but the service a patient receives may, of course, involve one or more consultants.

Activity Based Funding

In the case of public patients, the HSE has introduced a funding model for hospital care for inpatient and day-case services known as 'Activity Based Funding' (ABF) which means a specified price is paid to a hospital for each weighted unit of inpatient work and each weighted unit of day-case work. Emergency care, outpatient care and other services continue to receive traditional block grant allocations. For further information, see the Department of Health website at <https://health.gov.ie/future-health/structural-reform-2/money-follows-the-patient/>.

Appendix 2

Submissions received

Number	Name	Organisation	Date
1.	David Buttimer	None	04/01/18
2.	Brian Creedon	None	19/01/18
3.	John Doris	None	23/01/18
4.	William Kirwan	None	06/02/18
5.	Sean Tierney	None	07/02/18
6.	Eamonn Donnelly	FORSA	08/02/18
7.	Brendan Lynch	HIA	08/02/18
8.	John Hennessy	HSE	08/02/18
9.	Simon Nugent	Private Hospitals Association	08/02/18
10.	Sara Burke	Pathways to Universal Healthcare	08/02/18
11.	Jim Hussey	Rotunda Hospital	09/02/18
12.	Michael Cranston	None	09/02/18
13.	John Hyland	RCSI	09/02/18
14.	Dr Michael O'Sullivan, Dr Stephen Mannion, Dr Anthony Hennessy, Dr Clare Murray, Dr Jawad Mustafa	SOUTH INFIRMARY-VICTORIA UNIVERSITY HOSPITAL	09/02/18
15.	Pascale Claes	HSE - Clinical Strategy and Programmes Division	09/02/18
16.	Ann Barry	None	09/02/18
17.	Clare O' Byrne	HIQA	09/02/18
18.	Mary Horgan	Royal College of Physicians Ireland	09/02/18
19.	Michael Fitzgerald	None	09/02/18
20.	Liam Berney	Irish Congress of Trade Unions	09/02/18
21.	Michelle Fanning	Clontarf Hospital	09/02/18
22.	Kathryn Reilly & Paul Gordon	Health Reform Alliance	09/02/18
23.	David O'Keeffe	None	09/02/18
24.	Helen Whelton	None	09/02/18
25.	Roisin Shortall	TD	09/02/18
26.	Marie Lynch	The Irish Hospice Foundation	09/02/18
27.	Dónal Clancy	Laya Healthcare	09/02/18
28.	Ian Graham	Adelaide Health Foundation	09/02/18

Number	Name	Organisation	Date
29.	Phil Ni Sheaghda	Irish Nurses and Midwives Organisation	09/02/18
30.	Teresa Kelly Oroz	Irish Life Health	09/02/18
31.	Mike O' Connell	None	09/02/18
32.	Martin Varley	IHCA	09/02/18
33.	M. Chambers	None	09/02/18
34.	John Barton	None	09/02/18
35.	Brian Turner	None	09/02/18
36.	Mark Keogh	None	09/02/18
37.	Brigid Smyth	VHI	09/02/18
38.	Rosarii Mannion	HSE - Office of the National Director of Human Resources	14/02/18
39.	John Lamont	Dunbur Management Consulting	15/02/18
40.	Stephen McMahon	Irish Patients Association	20/02/18
41.	Sheila O' Connor	Patient Focus	25/02/18
42.	Anthony Owens	IMO	27/02/18
43.	Bill Prasifka	Medical Council Ireland	05/03/18
44.	John R. Higgins	None	06/03/18
45.	Joseph Campbell	Dublin Midlands Hospital Group	13/03/18
46.	Tony Baynes	Saolta University Health Care Group	27/03/18
47.	Paul Burke	UL Hospital Group	28/03/18

Table 17 - Submissions to the consultation on private activity in public hospitals

Appendix 3

Eligibility to services up to 2014

Eligibility in the period up to 1991

In the period leading up to the commencement of the Health (Amendment) Act 1991, the eligibility framework comprised of three distinct categories:

- Category I (lowest income group with medical card cover) – eligible for all public hospital services free of charge;
- Category II (middle income group) – same as Category I but liable for modest charges, e.g. an inpatient daily charge of £12.50 subject to certain exclusions and limits; and
- Category III – (top 15% of income earners) same as Category II subject to not being eligible for public consultant services. This category was therefore liable in full for private consultant fees.

As pointed out by Dr Brian Turner⁹⁰, the purpose of the establishment of the Voluntary Health Insurance Board under the Voluntary Health Insurance Act, 1957 was to give the top 15% of income earners (i.e. those described as Category III) a means of paying for hospital care that they might need without facing undue financial hardship.

While the main target group for private health insurance at the time was the top 15% of income earners, the purchase of voluntary health insurance was not limited to this group. Persons' with Category I or II eligibility could opt to access private consultant services in public hospitals on the same basis as Category III patients and it was felt that many started to do so because of the real or common perception that patients opting for private consultant care had preferential access to a bed in a public hospital. It should be noted that, prior to 1 June 1991, a patient opting for private consultant care in a public hospital retained their eligibility to a public bed.

This led to a growing concern that the admission arrangements for non-emergency procedures in public hospitals, particularly where a significant waiting list existed, may have operated to the disadvantage of public patients.

In addition, instead of availing of hospital services in a public hospital, a person eligible for public hospital services could arrange for similar services to be provided in any public or private hospital approved by the Minister for Health. In accordance with regulations made by the Minister, the relevant health board would fund the cost of these services.

⁹⁰ Dr Brian Turner, Department of Economics, Cork University Business School, University College Cork - Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/35..pdf>

Patients opting to be a private patient of a consultant would have their hospital care arranged by that consultant. This care could be provided in either a private hospital or, where available and if that consultant's contract so allowed, in a private bed in a public hospital. If a private bed was not available in the public hospital, the private patient care could also be delivered in a public bed in a public hospital.

It is worth noting that by 1991, approximately 30% of the population had private health insurance to cover the cost of private consultant fees and, of that 30%, it was estimated that 60% had Category I or II eligibility;

Eligibility in the period between 1991 and 2013

The Programme for Economic and Social Progress in 1991⁹¹, promised to introduce new arrangements for admission to public wards in public hospitals. A key objective of these new arrangements was to enhance the equity of access to public hospital services for public patients while continuing to acknowledge the role private health insurance played in funding services delivered in the public hospital system.

The Health (Amendment) Act 1991 provided the legislative basis to underpin these new arrangements. Detailed guidance on the intended method of implementation of these revised arrangements were set out in a number of Circulars, most notably Circulars 1/91 and 5/91.

A key element of the reform involved abolishing Category III eligibility (by abolishing the Category II income limit) resulting in a revised eligibility framework based on Category I and II eligibility only. As a result, with effect from 1 June 1991, all persons ordinarily resident in the State were eligible for all hospital services provided by the public hospital system.

Key principles underlying these new arrangements included:

- The public or private status of every patient must be identified;
- Private patients were liable for the fees of all consultants involved in their care;
- Private patients should in general be accommodated in expressly designated private or semi-private beds while public patients should in general be accommodated in public beds.
- Emergency cases should be admitted to whatever bed was available

Under these revised arrangements, patients could continue to avail of private consultant services in a public hospital. However, patients availing of elective inpatient

91 Programme for Economic and Social Progress, Government of Ireland, 1991, see https://www.taoiseach.gov.ie/eng/Publications/Publications_Archive/Publications_pre_1997/Programme_for_Economic_and_Social_Progress.html

care in public hospitals would, on a three year phased basis, be accommodated in private or semi-private beds only. The maintenance of separate waiting lists for public beds and for private / semi-private beds was an essential element of the new arrangements for elective admissions.

Under the new arrangements, private patients would continue to be liable for the private patient charges approved by the Minister (these charges encompassed the private patient daily maintenance charge and the equivalent of the statutory public inpatient charge). However, private patients were not liable for the private daily maintenance charges when occupying designated public beds and non-designated beds (e.g. Intensive Care beds), although they continued to be liable for the charge equivalent to the statutory public inpatient charge.

Circular 1/91 provided that during the three year phasing-in period these new arrangements, costing exercises would be undertaken to evaluate the implications of economic pricing for private accommodation and whether private patients should be liable for the private daily maintenance charges when occupying designated public or non-designated beds.

Under these revised arrangements, the definition of 'private status' under the Health Acts was that of a patient opting to avail of a private consultant service rather than public consultant services. Where a patient was being admitted arising from a private outpatient consultation, it was presumed that s/he was a private patient unless the patient specifies to the contrary and this is confirmed by the consultant.

However, if a patient admitted in emergency circumstances was unable to opt for either status but subsequently opts for private status, s/he was regarded as a private patient from admission and therefore liable for the fees of all consultants involved in his/her care from admission.

Under the revised framework, the Department of Health had responsibility for designating most acute beds in public hospital as either a public, semi-private or private bed. The purpose of the bed designation system was to protect access to public beds for public patients by ensuring that the volume of planned private activity was limited to the number of privately designated beds which were approved by the Department of Health. Presumably, this was designed to place an absolute cap on the rate of private activity in every hospital in Ireland.

Appendix 4

List of Hospitals in HIPE

Ireland East Hospital Group	County
St. Columcille's Hospital	Dublin
Mater Misericordiae University Hospital	Dublin
St. Vincent's University Hospital	Dublin
Cappagh National Orthopaedic Hospital	Dublin
St. Michael's Hospital	Dublin
Royal Victoria Eye and Ear Hospital	Dublin
National Maternity Hospital	Dublin
St. Luke's General Hospital	Kilkenny
Wexford General Hospital	Wexford
Midland Regional Hospital Mullingar	Westmeath
Our Lady's Hospital Navan	Meath
RCSI Hospital Group	
Connolly Hospital	Dublin
Beaumont Hospital	Dublin
The Rotunda Hospital	Dublin
St. Joseph's Hospital, Raheny	Dublin
Our Lady of Lourdes Hospital	Louth
Cavan General Hospital	Cavan
Louth County Hospital	Louth
Monaghan General Hospital	Monaghan
Dublin Midlands Hospital Group	
Naas General Hospital	Kildare
St. Luke's Hospital, Rathgar	Dublin
St. James's Hospital	Dublin
Coombe Women and Infants University Hospital	Dublin
Tallaght Hospital	Dublin
Midland Regional Hospital Tullamore	Offaly
Midland Regional Hospital Portlaoise	Laois
South/South West Hospital Group	
University Hospital Waterford	Waterford
Lourdes Orthopaedic Hospital (Kilcreene)	Kilkenny
South Tipperary General Hospital	Tipperary
Bantry General Hospital	Cork

Mercy University Hospital	Cork
South Infirmiry-Victoria University Hospital	Cork
Mallow General Hospital	Cork
Cork University Hospital	Cork
University Hospital Kerry	Kerry
University of Limerick Hospital Group	
University Maternity Hospital	Limerick
University Hospital Limerick	Limerick
Croom Hospital	Limerick
St. John's Hospital	Limerick
Ennis Hospital	Clare
Nenagh Hospital	Tipperary
Saolta Hospital Group	
Roscommon County Hospital	Roscommon
Portiuncula Hospital	Galway
Galway University Hospitals	Galway
Mayo General Hospital	Mayo
Letterkenny General Hospital	Donegal
Sligo Regional Hospital	Sligo
Children's Hospital Group	
Our Lady s Children s Hospital	Dublin
Children s University Hospital	Dublin
Tallaght Hospital	Dublin
No Group	
Peamount Hospital	Dublin
National Rehabilitation Centre, Dun Laoghaire	Dublin
Incorporated Orthopaedic Hospital, Clontarf	Dublin
St. Finbarr's Hospital	Cork

Table 18 - Hospitals participating in HIPE

Appendix 5 Hospital Group Discharges

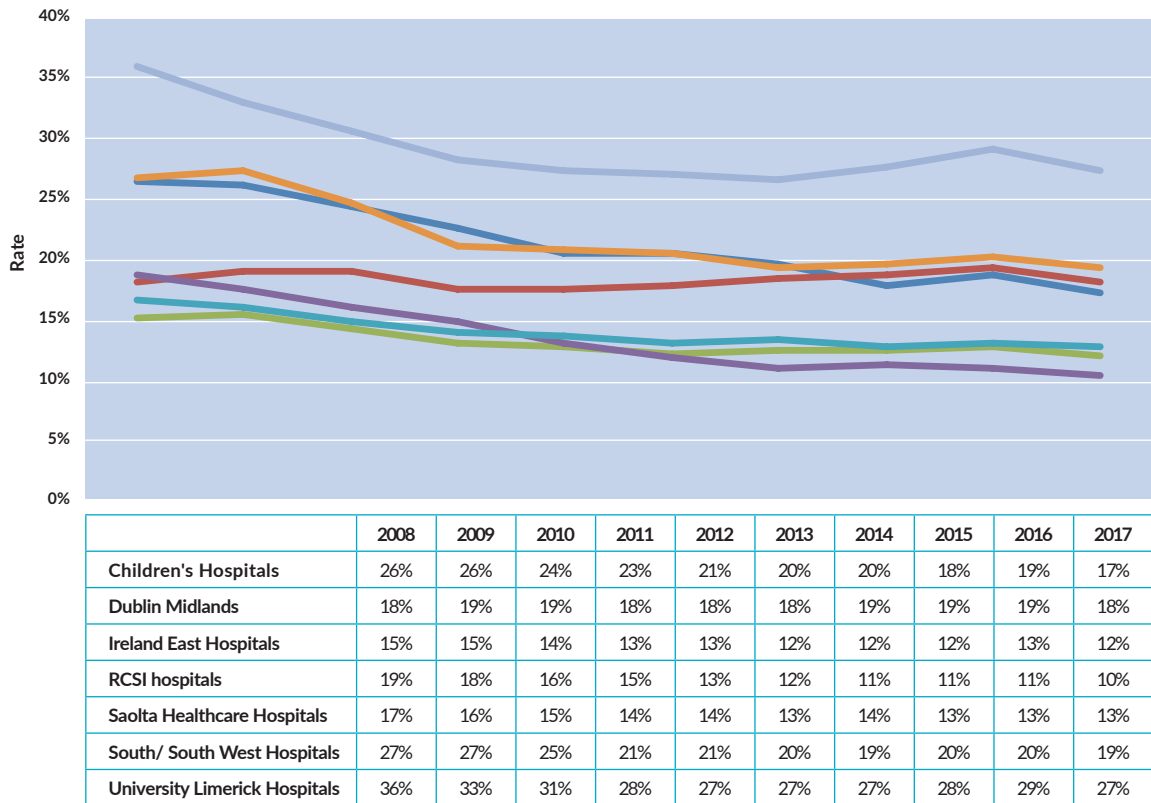


Figure 11 - Rate of private discharges by hospital group

The variations in the levels of private activity across the country are due to a number of factors including geographic access to private hospitals, the historic designation of private beds and the nature of consultant contracts.

The data also highlights some inconsistencies. For example, while the rate of private activity across all hospital groups at national level is 16%, the University Limerick Hospitals Group is 27%. This is a considerable variation from the average and is also consistent in each of the hospitals of the group, with three of the hospitals in the group at twice the national average:

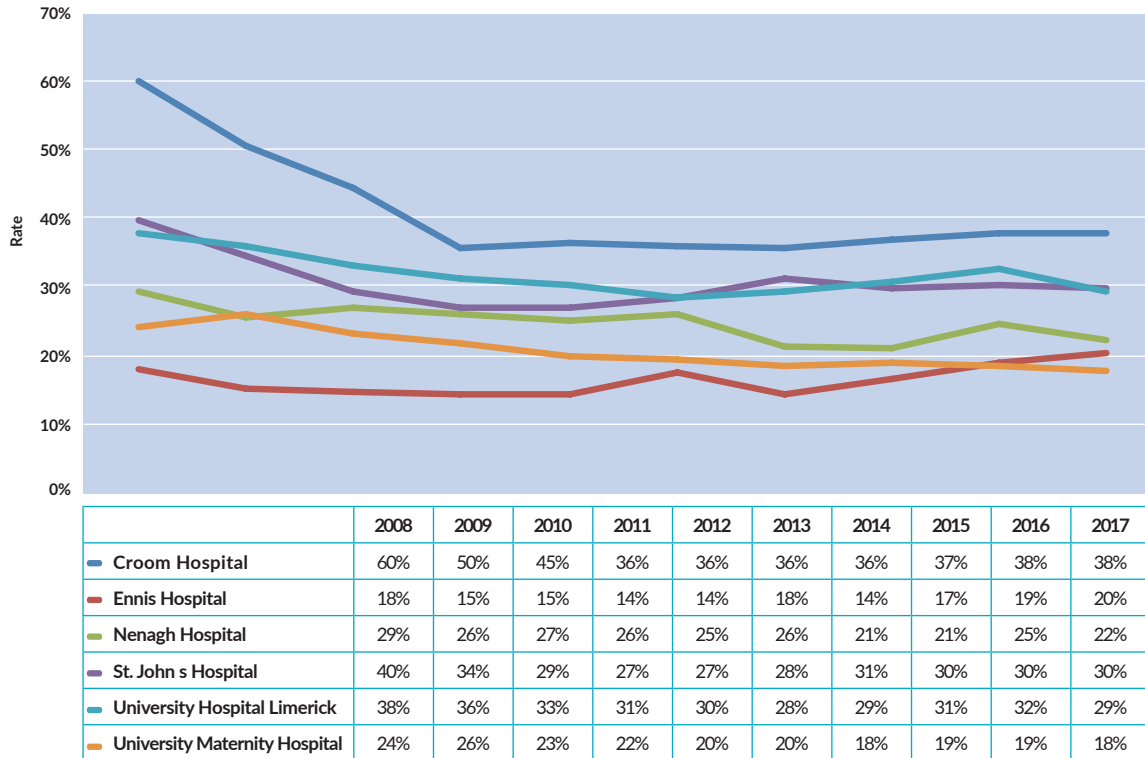


Figure 12 - Private discharges in the University of Limerick Hospital Group

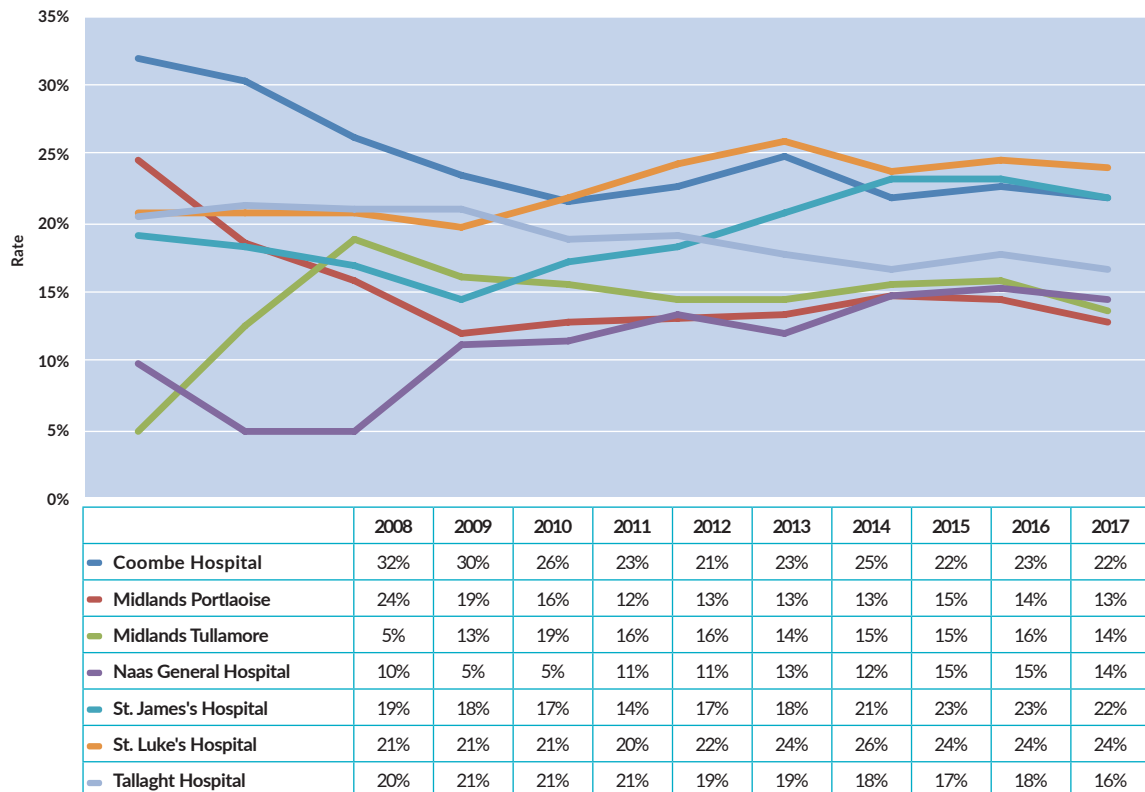


Figure 13 - Private discharges in Dublin Midlands Hospital Group

Dublin Midlands Hospital Group also appears not to match the national trend. Public and private activity (82% and 18% respectively) is the same in 2017 as it was in 2008 although the rates have been varying over time in most of the hospitals in the group. For example, private activity in Naas General Hospital has been as low as 5% but has increased to 14%.

Dublin Midlands Hospital Group also highlighted a particular issue driving demand in the hospital system. In their submission⁹², they have explained that St James' has "...70% of their inpatient cohort directly admitted through the Emergency Department pathway." It is interesting to note that public activity through emergency admission in the group has actually fallen, from 85% to 81%, over the period with a parallel rise in private activity. While the scale of St. James's Hospital admissions through EDs might not be replicated everywhere, the demand created by emergency admissions is a consistent issue in hospitals all over the country. Obviously, many people present at an ED because they are in need of urgent care, but it would also seem to be the case that there are many people turning up in EDs because they have no alternative, perhaps because they have been on long waiting lists for outpatient or elective care and their health has deteriorated to the extent that the ED is their only option. The issues in EDs are well-rehearsed in the public arena but it is clear that action is needed to reduce the demand placed on the system from unscheduled presentations in those hospitals with EDs.

It is notable that there are very clear differences in the rate of private activity when comparing inpatient and daycase activity. For example, there are significant differences between the rates of private inpatient and daycase activity in the Children's Hospital Group (22% against 15%) and Ireland East Hospital Group (18% and 8%). Some of this difference is presumably explainable due to access to services in private hospitals. For the same reasons, albeit in reverse, (and perhaps due to limited access to private hospitals), the rates in UL Hospitals are similar in inpatient and daycase.

92 Dublin Midlands Hospital Group Submission to the Independent Review Group On Removal of Private Practice from Public Hospitals, see <https://health.gov.ie/wp-content/uploads/2018/08/45..pdf>

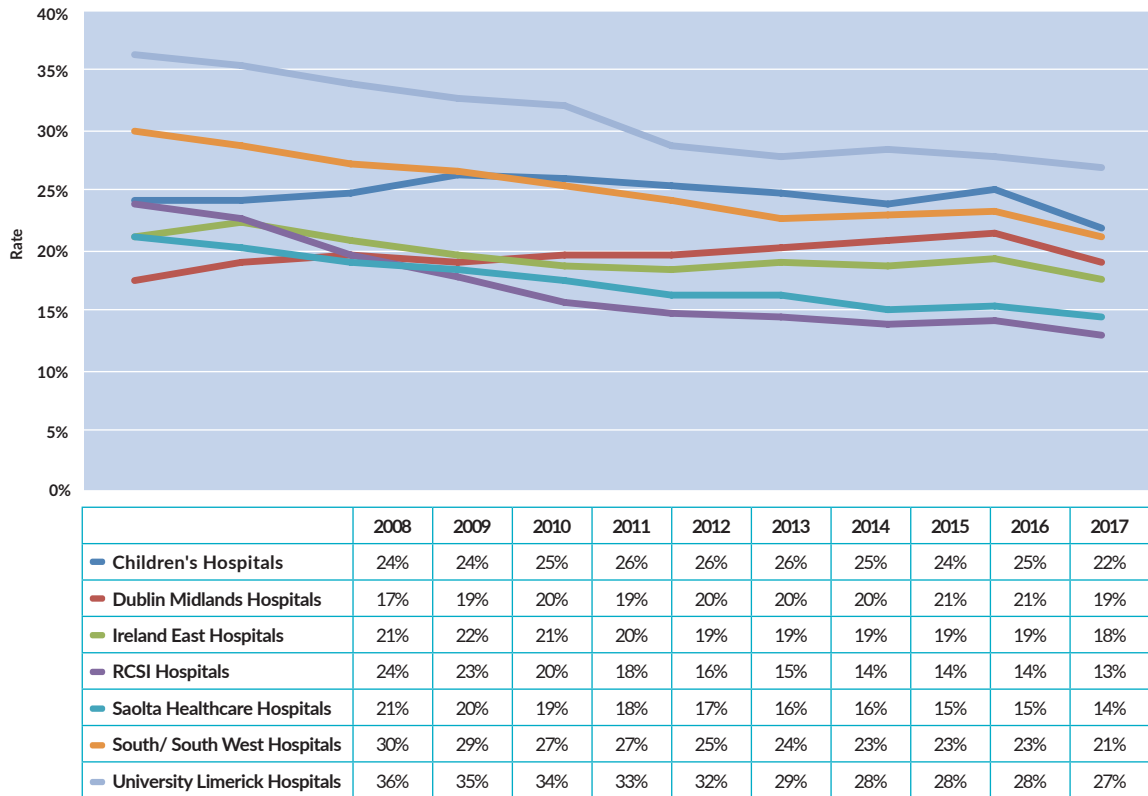


Figure 14 - Inpatient private discharges by hospital group

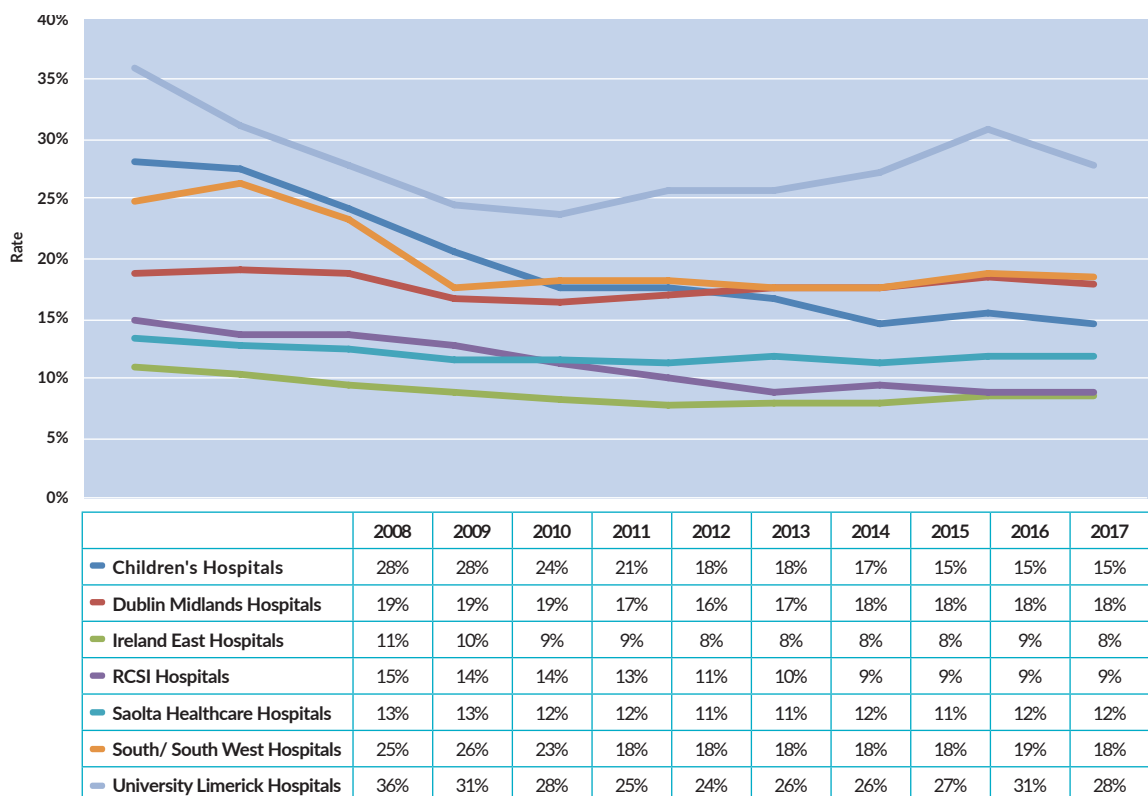


Figure 15 - Daycase private discharges by hospital group

As described previously, a significant proportion of those attending an Emergency Department in a hospital will subsequently be admitted to hospital and are included in HIPE. While it might be expected that a patient presenting at a public Emergency Department would be treated on a public basis, this is not the case with rates of private activity actually fairly similar to rates for other inpatient activity.

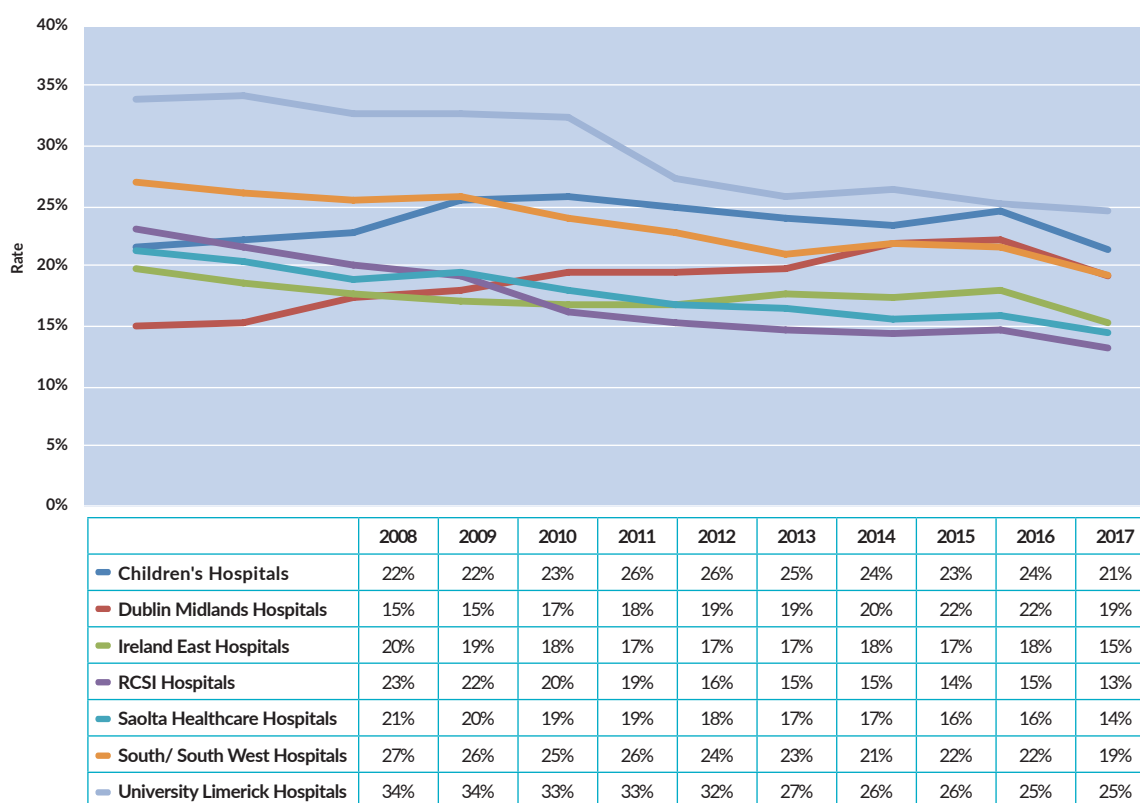


Figure 16 - Emergency discharges by hospital group

Appendix 6

Extract from 1997 contract Memorandum of Agreement

2.9 Private Practice

- 2.9.1 The Government has consistently affirmed its commitment to the availability of a mix of public and private care within the Irish health system. Most recently, this has been restated in the Health Strategy, Shaping a Healthier Future (1994). The Health Strategy also states that “it is important to ensure that the co-existence of public and private practice does not undermine the principle of equitable access”.
- 2.9.2 The agreement in relation to scheduling and organisation of work set out at Section 6 of the Contract is designed to demonstrate clearly that any entitlement to off-site private practice does not result in a reduction of contracted service to public sector patients whether public or private.
- 2.9.3 With regard to on-site private practice, a consultant’s overall proportion of private to public patients should reflect the ratio of public to private stay beds designated under the 1991 Health (Amendment) Act which requires that all public hospital beds be classified as public, private or non-designated. Variations in the nature or extent of a consultant’s work as between his public and private practices will be subject to review under the terms of Section 6 of the Memorandum of Agreement.
- 2.9.4 Each consultant will be entitled to engage in private practice within the hospital or hospitals in which he is employed. The extent to which a consultant is entitled to engage in private practice outside the hospital or hospitals in which he is employed is determined by the category of post which he holds (see section 3 of the Memorandum of Agreement) and subject to him satisfying the employing authority that he is fulfilling his contractual commitment to the public hospital(s).
- 2.9.5 Where a consultant is engaged in private practice within institution(s) financed from public funds, and with which he has a contract, then that private practice will be considered as on-site.
- 2.9.6 Conversely, where a consultant is engaged in private practice within institution(s) where the managing authority is separate from the public hospital and/or the hospital is financed from private funds, then that private practice will be considered as off-site.

2.9.7 Notwithstanding the provisions of paragraphs 2.9.4 and 2.9.5 above, a Category 1 Consultant who, by definition, devotes substantially the whole of his professional time to a public hospital cannot treat patients in a private hospital or clinic. He may, however, see private patients in consulting rooms which are not on the site of the public hospital. The nature and extent of the activities pursued in consulting rooms should not extend beyond consultation, examination of patients and the performance of minor treatments i.e. activities normally carried out in out-patient clinics. It does not encompass day-ward procedures involving anaesthesia. The principal criterion to be employed in assessing whether any particular activity falls within the permitted limits is the effect which it has on a consultant's ready availability to the public hospital. The long-term objective is to provide consulting rooms in the public hospital(s) which may be availed of by Category 1 Consultants to see fee paying patients. Occasional consultations at the request of another consultant are not precluded by the above provisions

Appendix 7

European Observatory Evidence Briefing

Comparator Countries experience with Private Practice in Public Hospitals

Evidence briefing on reducing private practice in public hospitals

Dublin, 19 June 2018

The European Observatory on Health Systems and Policies, a WHO-hosted network of international healthcare policymakers and academics, delivered an evidence briefing on private practice in public hospitals to assist the deliberations of the Review Group in developing this Report. The briefing took place in Dublin with two staff members of the Observatory and three visiting experts from Austria, France and Australia participating (see profiles at the end of this Appendix).

The overall aim of the evidence briefing was to support efforts to reduce inequalities in access to hospital care. One way to achieve this is by informing policy-making with experience from relevant other countries. To this end, the evidence briefing sought to support the work of the Review Group in developing this Report.

The key points shared with the Review Group confirmed the close relationships between public and private practice in the countries examined and in the wider experience of the visiting experts. It was also confirmed that similar issues with private practice in public hospitals are present in other countries, most of which have reported difficulties in monitoring and regulation of the practice. Public hospitals are often incentivised to generate extra income from private practice and will often use the practice to recruit and retain doctors. The experts reported that tighter regulation and monitoring of practice activity is key to controlling the effects of private practice on public hospitals and patients.

It is worth noting that there are significant differences between the three countries examined and Ireland. One is that the three comparator countries have universal healthcare, unlike Ireland. Another is that while the experts agreed that problems relating to regulation and monitoring of practice activity exist in other countries, this is within the context of fewer problems generally in accessing public health services. In other words, waiting times for services in the reporting countries are lower than in Ireland so issues such as access and equity are less acute problems. There are also significant differences between the reporting countries: for example, 45% of Australia's population has voluntary private insurance cover, a figure much the same as Ireland's, while only 20% in Austria have voluntary private health insurance (VPHI) but fully 95% of French people have VPHI (in France, insurance is used to cover co-payments).

The briefing papers supplied to the Review Group are available on the Department of Health website.

What follows is taken from the evidence briefings and papers and is presented country by country - Australia, Austria and France - with Key Summary Information presented first and Background Information included thereafter.

Australia - Summary of Key Information

Background - How the Australian Health System works

Health care in Australia is based on the Medicare system. It is a publicly funded, universal health care system where residents can choose whether to have Medicare cover only or a combination of Medicare and private health insurance.

Main features of Medicare:

- Eligible residents can receive free treatment as a public patient in a public hospital, even if they hold private health insurance (they may also elect to be treated privately).
- Medicare is supplemented by a Private Health Insurance Rebate, where the Government funds up to 30% of any private health insurance premium covering people who are eligible for Medicare.
- If a resident chooses not to take out a private hospital insurance policy and they earn above a certain income threshold, they may have to pay the Medicare Levy Surcharge.

Main features of private health insurance in Australia:

- Private health insurance in Australia is community rated which means that everyone pays the same for health insurance and health funds cannot discriminate against members based on their age, health status or claims history.
- In July 2000, the Government introduced Lifetime Health Cover (LHC) which was designed to encourage people to take out private health insurance earlier in life, and to maintain it.
- If a member takes out private health insurance later in life, a 2% loading applies to health insurance premiums for every year that a member is aged over 30 years.
- The LHC loading is removed after a 10 year period.
- Private health insurance offers members greater choice of providers, faster access for non-emergency services and rebates for selected services. It can include cover for hospital care, general treatment or ambulance services.
- 45.5% of the population have hospital cover⁹³.

93 According to the Australian Prudential Regulation Authority (APRA) 45.5% of the population held hospital treatment membership at 31 March 2018. <https://www.apra.gov.au/sites/default/files/1805-QPHIS-20180331.pdf>

Private Practice in Australia

Patients can choose to be treated either publicly or privately in a public hospital. If they wish to be treated privately they must declare before admission (or, in the case of emergency visits, after).

- As a public patient, all treatment costs will be covered by Medicare. This type of patient may encounter long wait times for elective surgery or medical care.
- Patients who elect to be treated privately in a public hospital will have a choice of doctor; however, they may encounter co-payments⁹⁴.
- Private patients in private hospitals will have a choice of doctor, facility and accommodation. This type of patient may enjoy shorter waiting times.

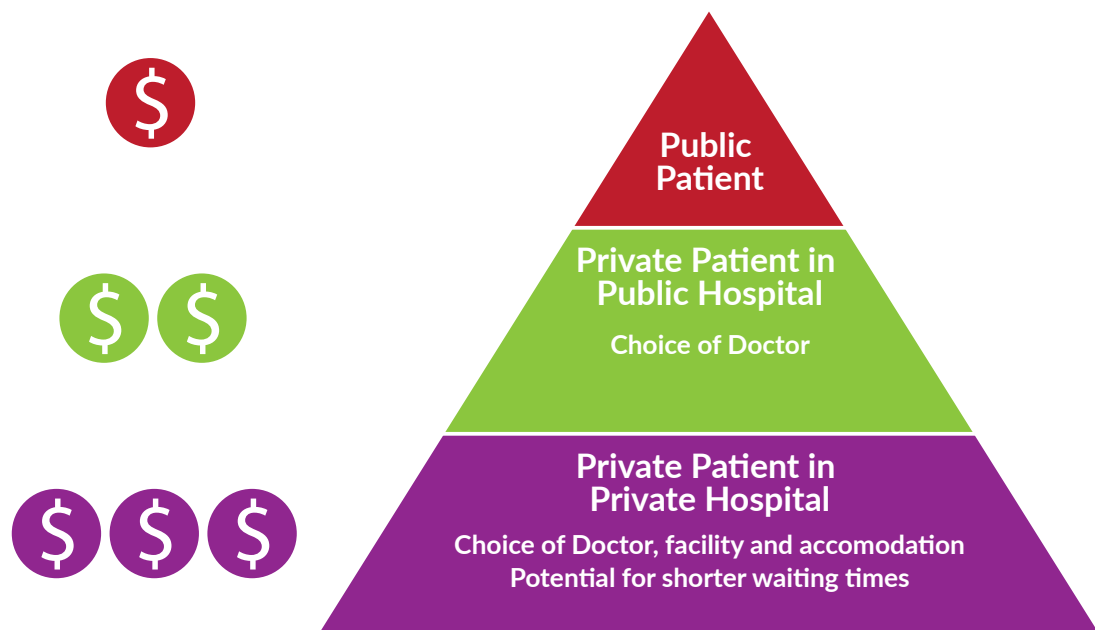


Figure 17 - private healthcare in Australia

⁹⁴ As private patients in public hospital there could be co-payments depending on whether they are treated by a salaried or visiting doctor (self-employed) as not all costs will be covered by Medicare.

Employment of Doctors in Australian hospitals

Specialist services are provided in public hospitals or in private practices. Specialists can set their own fees and are paid on a fee for service basis and many specialists will split their time between the public and private sector (doctors working in public hospitals are either employed publicly or are self-employed).

According to Ian Brownwood, an OECD healthcare expert with long experience working with regional health ministries in Australia (see profile below), it is estimated that 50% of specialists working in public hospitals have rights of private practice. Each State in Australia has different arrangements but the following key options exist:

- Assignment (allowance paid to the doctor).
- Retention (facility charge and administration fee).
- Sharing (hospital and doctor share).

A 2013 study found that 33% of specialists work only in the public sector (roughly 20% work only in the private sector); however, almost half of Australian specialists combine both public and private sector work. Of the 33% of public sector specialists, almost 49% have rights to private practice.⁹⁵

Some key features of employment in public hospitals in Australia:

- Specialists who work in public hospitals are either publicly employed or self-employed. Publicly employed specialists are usually allowed to treat private patients in the same hospital.
- Specialists can charge patients on a fee-basis but will transfer at least some part of the fees to the hospital. They also have the option to forgo the right to bill themselves and allow the hospital to process the fees in return for a higher salary.
- Self-employed doctors also work on a fee-basis; however, they are required to pay the hospital for the use of the facilities.

Side Effects of Private Practice in Public Hospitals

The Federal and State Governments provide the majority of funding for public hospitals (91%), The remainder comes from private patients and health funds. As a result, States tend to encourage hospitals to generate income from private patients. Therefore, hospitals seek to encourage patients to use their private health insurance when they enter the hospital in an effort to maximise revenue.

⁹⁵ Source: 'An empirical analysis of public and private medical practice in Australia', 2013, Terence Chai Cheng, Catherine M Joyce, Anthony Scott, Melbourne Institute of Applied Economic and Social Research, The University of Melbourne, Department of Epidemiology and Preventative Medicine, Monash University.

Some incentives to have patients elect for private patient status:

- Seek to ensure full insurance coverage of costs.
- Accommodation fees set lower than the full cost of recovery (e.g. \$300 per day in a shared ward).
- Having full-time employed medical specialists presents a lower risk of gap payments.
- Waiving out of pocket payments for visiting specialists.

Regulation / Monitoring:

Regulation of private practice and employment contracts are the responsibility of the individual States. For example, in Queensland Senior Medical Officers (SMOs) must work the contracted 80 hours per fortnight. Beyond this they can use their time as they wish (which may include private work in private facilities). Many of the SMOs have the right to treat private patients in public hospitals and either receive an allowance or retain parts of the fees charged to the patients⁹⁶.

The Government of Australia have considered the following options to reduce private health insurance cost pressures:

- Limit benefits to the medical costs with no benefits paid to the hospital for facility fees.
- Prevent public hospitals from waiving any excess payable by patients.
- Remove the requirement to pay benefits for public hospital emergency admissions.
- Remove the requirement to pay benefits for episodes where there is no meaningful choice of doctor or doctor involvement.
- Make changes to the national payment determination and funding model to take account of all private patient revenue.

Australia – Background Information

What is the role of government?

Three levels of government are collectively responsible for providing universal health care: federal; state and territory; and local. The federal government mainly provides funding and indirect support to the states and health professions, subsidising primary care providers through the Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) and providing funds for state services. It has only a limited role in direct service delivery.

States have the majority of responsibility for public hospitals, ambulance services, public dental care, community health services, and mental health care. They contribute their own funding in addition to that provided by federal government. Local governments play a role in the delivery of community health and preventive health programs, such as immunisation and the regulation of food standards.

Who is covered and how is insurance financed?

Publicly financed health insurance: Total health expenditures in 2014–2015 represented 10.0 percent of GDP, an increase of 2.8 percent from 2013–2014. Two-thirds of these expenditures (67.0%) came from government. The federal government funds Medicare, a universal public health insurance program providing free or subsidised access to care for Australian citizens, residents with a permanent visa, and New Zealand citizens following their enrolment in the program and confirmation of identity. Restricted access is provided to citizens of certain other countries through formal agreements. Other visitors to Australia do not have access to Medicare. Medicare is funded in part by a government levy collected through the tax system.

Private health insurance: Private health insurance (PHI) is readily available and offers more choice of providers (particularly in hospitals), faster access for non-emergency services, and rebates for selected services. Insurers are a mix of for-profit and non-profit providers. In 2014–2015, private health insurance expenditures represented 8.7 percent of all health spending. Government policies encourage enrolment in PHI through a tax rebate and, above a certain income, a penalty payment for not having PHI (the Medicare Levy surcharge). The Lifetime Health Coverage program provides a lower premium for life if participants sign up before age 31. For people who do not sign up, there is a 2 percent increase in the base premium for each year after age 30. Consequently, take-up is highest among those 30 and under but rapidly drops off as age increases, with a trend to opt out starting at age 50.

Nearly half of the Australian population (47%) had private hospital coverage and nearly 56 percent had general treatment coverage in 2016. Private health insurance coverage varies by socioeconomic status. PHI covers just one in five (22.1%) of the

most disadvantaged 20 percent of the population, a proportion that rises to more than 57.2 percent for the most advantaged population quintile. This disparity is due in part to the Medicare Levy surcharge applied to higher-income earners.

Private health insurance can include coverage for hospital care, general treatment, or ambulance services. When accessing hospital services, patients can opt to be treated as a public patient (with full fee coverage) or as a private patient (with 75% fee coverage). For private patients, insurance covers the MBS fee. If a provider charges above the MBS fee, the consumer will bear the gap cost unless they have gap coverage. The patient may also be charged for costs such as hospital accommodation, surgery fees (implants and theatre fees), and diagnostic tests.

What is covered under Medicare?

Services: The federal government defines and funds Medicare benefits, which include hospital care, medical services, and pharmaceuticals, to name a few. States provide further funding and are responsible for the delivery of free public hospital services, including subsidies and incentive payments in the areas of prevention, chronic disease management, and mental health care. The MBS provides for limited optometry and children's dental care.

Pharmaceutical subsidies are provided through the PBS. To be listed, pharmaceuticals need to be approved for cost-effectiveness by the independent Pharmaceutical Benefits Advisory Committee (PBAC). War veterans, the widowed, and their dependents may be eligible for the Repatriation PBS.

Nearly half (49%) of federal support for mental health is for payments to people with a disability; the remaining support goes toward payments to states, payments and allowances for caregivers, and subsidies provided through the MBS and PBS. State governments are responsible for specialist and acute mental care services.

Cost-sharing and out-of-pocket spending: Out-of-pocket payments accounted for 18 percent of total health expenditures in 2013–2014. The largest share (38%) was for medications, followed by dental care (20%), medical services (e.g., referred and unreferred private health insurance), medical aids and equipment, and other health practitioner services.

There are no deductibles or out-of-pocket costs for public patients receiving public hospital services. General practitioner (GP) visits are subsidised at 100 percent of the MBS fee, and specialist visits at 85 percent. GPs and specialists can choose whether to charge above the MBS fee. About 83 percent of GP visits were provided without charge to the patient in 2014–2015. Patients who were charged paid an average of AUD31 (€18).

Out-of-pocket pharmaceutical expenditures are capped. In 2016, the maximum cost per prescription for low-income earners was set at AUD6.20 (€3.50), with an annual cap of AUD372.00 (€234). For the general population, the cap per prescription is AUD38.30 (€24), which reverts to the low-income cost cap if a patient incurs more than AUD1,476.00 (€930) in out-of-pocket expenditure within a year. Consumers pay the full price of medicines not listed on the PBS. Pharmaceuticals provided to inpatients in public hospitals are generally free.

Safety nets: There are three safety nets. The Original Medicare Safety Net covers the cost of all Medicare services out of hospital above an annual out-of-pocket threshold of AUD447 (€281). The Extended Medicare Safety Net covers 80 percent of out-of-pocket costs over an annual threshold of AUD648 (€408) for those with government-issued concession cards (e.g., low-income, seniors, caregivers) and AUD2,030 (€1,278) for others. The “Greatest Permissible Gap” sets the maximum out-of-pocket fee per out-of-hospital service at AUD79.50 (€50). The government is seeking to replace these with a single Medicare Safety Net that would reimburse 80 percent of out-of-pocket costs (up to a cap of 150 percent of the MBS fee) for the remainder of the calendar year once annual thresholds are met: AUD638 (€402) for concessional patients (including low-income adults, children under 16, and certain veterans); AUD648 (€408) for parents of school children; and AUD2,030 (€1,278) for singles and all other families.

How is the delivery system organised and financed?

Primary care: In 2015, there were 34,367 GPs, 49,060 practitioners registered as generalists and specialists, and 8,386 specialists. GPs are typically self-employed, with about four per practice on average. In 2012, those in non-managerial positions earned an average of AUD2,862 (USD1,858) per week. The schedule of service fees is set by the federal health minister through the MBS.

Registration with a GP is not required, and patients choose their primary care doctor. GPs operate as gatekeepers, in that a referral to a specialist is needed for a patient to receive the MBS subsidy for specialist services. The fee-for-service MBS model accounts for the majority of federal expenditures on GPs, while the Practice Incentives Program (PIP) accounts for 5.5 percent.

State community health centres usually employ a multidisciplinary provider team. The federal government provides financial incentives for the accreditation of GPs, for multidisciplinary care approaches, and for care coordination through PIP and through funding of GP “Super Clinics” and Primary Health Networks (PHNs). PHNs (which have replaced Medicare Locals) are being implemented in 2015–2016 to support more efficient, effective, and coordinated primary care.

In 2015, there were 11,040 nurses or midwives working in a general practice setting. Their role has been expanding with the support of the PIP practice nurse payment. Nurses are also funded through practice earnings. Nurses in general practice settings provide chronic-disease management and care coordination; preventive health education; and oversight of patient follow-up and reminder systems.

Outpatient specialist care: Specialists deliver outpatient care in private practice (8,001 specialists in 2015) or in a public hospital (3,745). Patients are able to choose which specialist they see, but must be referred by their GP to receive MBS subsidies. Specialists are paid on a fee-for-service basis. They receive a subsidy through the MBS of 85 percent of the schedule fee and set their patients' out-of-pocket fees independently. Many specialists split their time between private and public practice.

Administrative mechanisms for direct patient payments to providers: Many practices have the technology to process claims electronically so that reimbursements from public and private payers are instantaneous, and patients pay only their co-payment (if the provider charges above the MBS fee). If the technology is not in place, patients pay the full fee and seek reimbursement from Medicare and/or their private insurer.

After-hours care: GPs are required to ensure that after-hours care is available to patients but are not required to provide care directly. They must demonstrate that processes are in place for patients to obtain information about after-hours care and that patients can contact them in an emergency. After-hours walk-in services are available and may be provided in a primary care setting or within hospitals. As there is free access to emergency departments, these also may be utilised for after-hours primary care.

The federal government provides varying levels of practice incentives for after-hours care, depending on whether access is direct or provided indirectly through arrangements with other practitioners in the area. Government also funds PHNs' support for and coordination of after-hours services, and there is an after-hours advice and support line.

Hospitals: In 2014–2015, there were 698 public hospitals (678 acute, 20 psychiatric), with a total of nearly 60,300 beds, an increase of 1,700 beds over the previous year, despite there being 20 fewer hospitals. In the same period, there were 624 private hospitals (342 day hospitals and 282 others) with 32,000 beds. Private hospitals are a mix of for-profit and non-profit.

Public hospitals receive a majority of funding (91%) from the federal government and state governments, with the remainder coming from private patients and their insurers. Most of the funding (62% of the total recurrent expenditure) is for public-physician salaries. Private physicians providing public services are paid on a per-

session or fee-for-service basis. Private hospitals receive most of their funding from insurers (47%), federal government's rebate on health insurance premiums (21%), and private patients (12%).

Public hospitals are organised into Local Hospital Networks (LHNs), of which there were 147 in 2016. These vary in size, depending on the population they serve and the extent to which linking services and specialties on a regional basis is beneficial. In major urban areas, a number of LHNs comprise just one hospital.

State governments fund their public hospitals largely on an activity basis, using diagnosis-related groups. Federal funding for public hospitals includes a base level of funding, with funding for growth set at 45 percent of the "efficient price of services," determined by the Independent Hospital Pricing Authority. From July 2017, the Commonwealth will fund 45 percent of the efficient growth in these services, capped at 6.5 percent of total growth. States are required to cover the remaining cost of services, providing an incentive to keep costs at the efficient price or lower. Small rural hospitals are funded through block grants.

How are costs contained?

The major drivers of cost growth are the MBS and PBS. The federal government regularly considers opportunities to reduce spending growth in the MBS through its annual budget process and has established an expert panel to undertake a review of the entire schedule and to report by the end of 2016.

Hospital funding is set through policy decisions by the federal government, with states required to manage funding within their budgets. Beyond these measures, the major control is through the capacity constraints of the health system, such as workforce supply.

This content is taken from:

Lucinda Glover (2017) *The Australian Health Care System, International Health Care System Profiles*, The Commonwealth Fund.

The full report can be accessed here:

<https://international.commonwealthfund.org/countries/australia/>

Austria – Summary of Key Information

Background - How the Austrian Health System works

Governance of the Austrian health care system is shared between the federal and regional level. The responsibility for the system lies with the federal government with the 9 federal states (Länder) holding responsibility for implementing legislation in the hospital sector.

Main features of the Austrian health care system:

- 18 social health insurance funds (including one for each of the 9 regions) come together under the Main Association of Austrian Social Security Institutions.
- These funds collectively negotiate with the regional Medical Chambers and other health care professions regarding health care provision.
- Spending on health care is high with inpatient care accounting for a large share.
- Social insurance funds provide universal coverage that is automatically determined by place of occupation.
- The contributions for health are generally fixed at 7.65% of gross income.
- Insurance funds pay for ambulatory care by contracted physicians.
- Patients can also choose to see non-contracted physicians and are reimbursed 80% of what insurance would usually pay for contracted care.
- Austria has a large hospital sector.
- Patients have free choice of provider and unrestricted access to all levels of care.

Main features of private health insurance in Austria:

- 19.8% of the population hold a voluntary health insurance plan that covers hospital costs.
- All doctors in fund hospitals are employed; however, they can receive fees when treating private patients (people in the Sonderklasse).
- Sonderklasse offers better amenities such as a double or single room in the hospital and better food options and the choice of doctor (paid for by VHI and out of pocket payments).

Private Practice in Austria

All doctors employed in one of the 117 'fund hospitals' in Austria are employees; however, they can treat patients in the Sonderklasse. A large number of these doctors also operate a private practice or work in private hospitals where they have an opportunity to earn extra income.

Main features of private practice in Austrian public hospitals:

- Private practice in public hospitals generates additional income not only for doctors but for the hospital also.
- There is a considerable gradient in both salaries and the opportunity for doctors to earn additional income from private practice and this incentivises very competitive behaviour.
- Private patients are treated differently to public patients: quite often students do not treat people in the Sonderklasse; some hospital department heads only visit Sonderklasse; wait times are shorter for patients that hold private health insurance or visit a doctor in their private practice or make ‘under the table’ payments.
- Doctors who practice privately in the public hospital must make an ‘infrastructure contribution’ for the use of the hospital facilities in a private capacity.
- The number of Sonderklasse beds in public hospitals is limited to 25% (this can act as an incentive to keep up bed capacity and may explain the high number of acute beds in Austria).
- Public hospitals use the opportunity to practise privately in a public hospital as a recruitment tool for doctors.

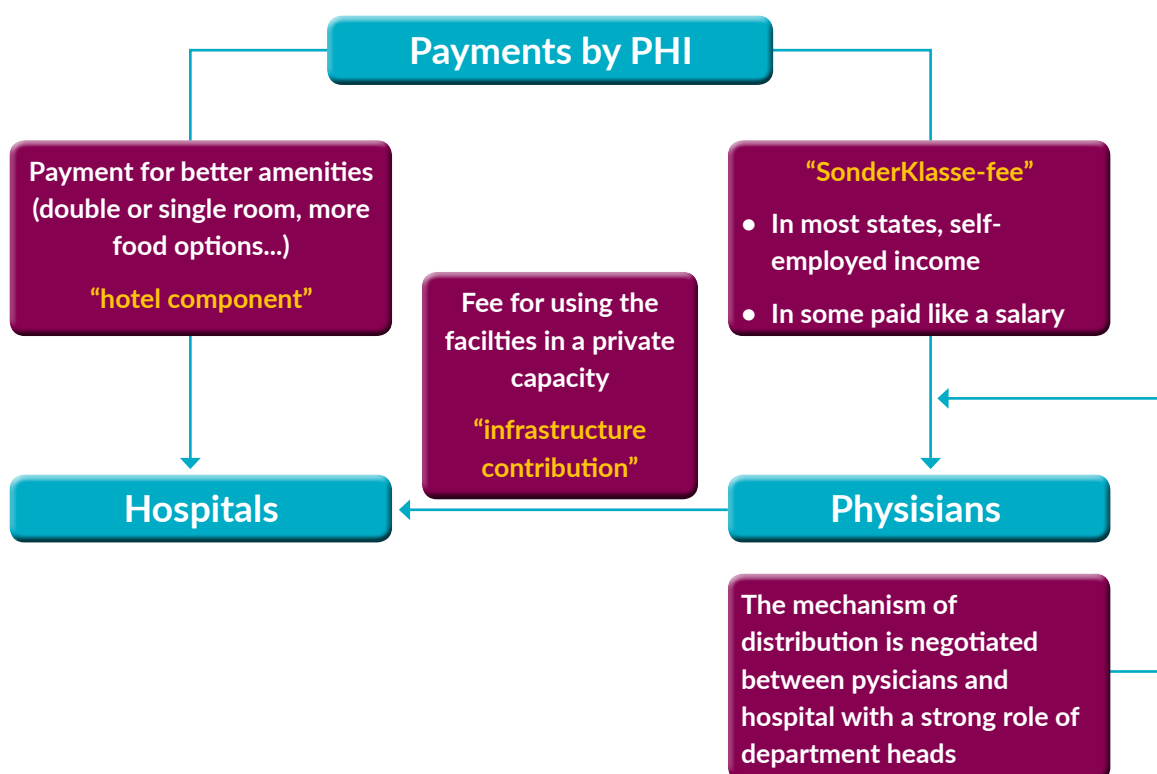


Figure 18 - Private health insurance payments in Austria

Side Effects of Private Practice in Public Hospitals

There are some side effects of private practice in Austrian hospitals:

- It diverts resources from the public hospital.
- It presents an opportunity for receiving informal payments from patients.
- Doctors may engage in 'cream skimming' i.e. performing procedures that are barely cost covering in the public hospital while undertaking lucrative ones in private practice or in a private hospital.
- The financial perks of private practice encourage competitive behaviour among doctors.
- Doctors are incentivised to treat private patients differently.
- The waiting times for private patients are considerably less than for public patients.
- Patients can see a doctor in their private practice and there is a possibility to make 'under the table' payments.

Regulation / Monitoring

Reform measures were introduced in 2012 following articles in the Austrian press concerning a two-tier system and a focus on waiting times for patients.

Main reform measures adopted:

- The States are required to have a transparent waiting time system for certain elective surgical and invasive diagnostic procedures.
- They must define a list of criteria on how to rank people on the waiting list.
- States must oblige hospitals to include the total number of people on the waiting list (including those with Sonderklasse status).
- Legislation sets out that a hospital can be considered non-profit and eligible for participation in the state health fund financing only if:
 - Hospital activities are not for profit.
 - Patients are admitted based on clinical need and treated only based on their health condition (public or private status is irrelevant).
 - Hospital employees must not accept any payment from patients or their relatives.
 - The number of beds dedicated to Sonderklasse is limited to 25% of total bed capacity.
 - Public patients must be admitted to Sonderklasse if there are no normal beds available.

Austria – Background Information

Austria’s complex health system has been reformed to improve governance

The Austrian health system is complex: governance is shared between the federal and the regional level (“Länder”); many responsibilities have been delegated to self-governing bodies (social insurance and providers); and health care financing is mixed, with the federal level, the regional level (Länder and municipalities) and social insurance funds all contributing to the budget.

The federal government is responsible for regulating social insurance and most areas of health care provision – except hospital care, where the basics are defined at the federal level but the Länder are responsible for the specifics of legislation and implementation. Eighteen social health insurance funds, including one for each of the nine regions, come together under the Main Association of Austrian Social Security Institutions (including also the pension and accident insurance funds). Social insurance funds collectively negotiate with regional Medical Chambers and other health professions regarding health care provision in the areas of ambulatory (or outpatient) and rehabilitative care and pharmaceuticals.

Decentralised planning and delegation of responsibilities allow decision making to be adjusted to local needs – but often also lead to fragmentation and inadequate coordination. Efforts were made over a number of years to achieve more joint planning, governance and financing by bringing together the federal and regional levels and coordinating these with social insurance funds. The 2013 health reform was an important step in this direction, introducing a federal and nine regional commissions on health system governance involving all relevant actors.

Austrian health spending is high, with inpatient care accounting for a relatively large share

The Austrian health system is relatively expensive. Around EUR 3,800 was spent on health per capita in 2015 (adjusted for differences in purchasing power), about EUR 1,000 more than the EU average. However, in relative terms, health expenditure in Austria (10.3% of GDP) has grown more slowly than in many other EU Member States since 2005 and is only slightly above the EU average (9.9% of GDP). Nonetheless, Austria’s health care expenditure is projected to grow substantially over the next decades.

Social insurance funds are the main source of financing, contributing 44.8% of current health expenditure in 2015. Coverage is universal and automatically determined by place of occupation. Contributions for health are generally fixed at 7.65% of gross income (shared between employees and employers). There is no competition between funds. All cover broadly the same benefits although some differences exist.

Insurance funds pay for ambulatory care provided by contracted physicians, using a mix of contact capitation and fee-for-service. Patients can also see non-contracted physicians but are reimbursed only for 80% of what insurance would usually pay for contracted care. Payments for non-contracted care account for a large share of out-of-pocket spending.

The share of direct government spending – mostly related to contributions of the Länder for the financing of inpatient care – increased slowly over time. Austria spends more than one-third of its health expenditure on inpatient care – a share that is higher only in Greece and Poland. In 2005, a Regional Health Fund was established in each region, pooling resources from federal authorities, Länder, and social insurance funds. Since then, the Regional Health Funds pay for inpatient care provided by public and non-profit hospitals on the basis of an Austrian version of Diagnosis Related Groups.

A large hospital sector and the second highest number of physicians in the EU

Austria has a very large hospital sector. Despite official plans to reduce the number of hospital beds, the bed-per-population ratio in Austria remains the second highest in the EU after Germany. Bed numbers have reduced by only 5% since 2000, while countries like Finland or Denmark made reductions of around 40% over the same period. The density of major medical equipment (CT, MRI, PET scanners) is also above average in Austria but mostly concentrated in hospitals.

Austria has the second highest physician-to-population ratio in the EU after Greece. It has also trained a lot of medical students, which explains the rising number of physicians – from 3.9 to 5.1 practising physicians per 1 000 population between 2000 and 2015. However, due to a quota on first-year students introduced in 2006, Austria witnessed a substantial decline in medical graduates in recent years. Further, as most physicians work in hospitals and/or as specialists, only 15% work as General Practitioners (GPs) in private practice.

Free choice of provider and no gatekeeping contribute to high hospital activity

Patients in Austria benefit from free choice of provider and unrestricted access to all levels of care (GPs, specialists and hospitals). They can choose to access not only contracted but also non-contracted physicians, the latter of which steadily increased in recent years. Yet this may contribute to social and regional inequalities.

A major aim of current health reforms is to strengthen the comparatively weak primary care system. In addition, efforts are made to improve coordination through the introduction of disease management programmes – but unlike in Germany, this has so far been limited to patients with diabetes. Prevention continues to be relatively underfunded, accounting for only 2.2% of health expenditure in 2015 – only two-thirds of what EU countries spend on prevention on average (3.1%).

Austria is characterised by a very high level of activity in inpatient care. It has the second highest number of discharges in the EU after Bulgaria, though numbers have steadily declined since 2008. More than one out of four Austrians are discharged from a hospital every year (256 discharges per 1 000 population). In fact, Austria has the highest number of knee replacements in the EU and the second highest number of hip replacements.

This content is taken from:

OECD/European Observatory on Health Systems and Policies (2017), *Austria: Country Health Profile 2017, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

The full report can be accessed here: http://www.euro.who.int/__data/assets/pdf_file/0004/355873/Health-Profile-Austria-Eng.pdf?ua=1

France – Summary of Key Information

Background - How the French Health System works

The French health care system is based on social insurance. Social Health Insurance (SHI) funding is based on income related contributions from employers and employees and it includes Government Transfers. The management of the health service is split between the SHI and the state.

Main features of SHI:

- All legal residents of France are covered by SHI.
- The scheme is administered by a number of non-competing health insurance funds.
- These funds cater for different sectors of the labour market (the main fund covers 91% of the population with the other two covering self-employed people and agricultural workers).
- Legislative changes in 2000 and 2016 allowed for around 3.8% of the population to be covered under residency status to ensure that this cohort benefit from the same rights as the rest of the population.
- The SHI benefits package is broad in terms of coverage (cover includes: hospital care, treatment in both public and private institutions, GP Outpatient care, specialists, dentists, midwives and all other services prescribed by doctors).
- Cover is fairly limited in relation to eyeglasses and contact lenses and dental prostheses. SHI also does not cover extra costs over the statutory charges.
- ‘Sector 2’ doctors can set their own fees which must be paid by the patients or their private health insurance.
- Services are delivered by a mix of public and private providers (primary care is generally provided privately by individual doctors or group practices. Outpatient specialist services can be delivered in hospitals or private practices).

Main features of private health insurance in France:

- Voluntary complementary health insurance plays an important role in France.
- Private health insurance provides complementary insurance for co-payments.
- It also provides better cover for medical goods and services that are poorly covered by SHI.
- Approximately 95% of the population hold private health insurance.

Private Practice in France

French doctors, working in public hospitals, have the option of private practice (activité libérale), which allows them to provide consultations, procedures and/or care in public hospitals. There are certain conditions under which private practice may take place:

- The doctor should only develop private practice in a principal activity of the same nature as their public work.
- Private practice should not exceed 20% of their work in the public hospital.
- The number of private consultations and procedures should be less than those provided in the public hospital.
- Doctors may not reserve beds or equipment in the public hospital for private activity.
- Patients are admitted at their request and must be made aware of all fees that will be reimbursed, the amount of possible fee above the reimbursement level and the conditions of reimbursement from health insurance; the patient must confirm this decision in writing.
- If a patient has elected to avail of private practice they cannot be transferred to the public sector (it is also not possible to transfer from public to private). In exceptional circumstances the CEO of the hospital can authorise the transfer based on a request from the patient and on the advice of the person in charge of the unit.

Employment of Doctors in French hospitals

68% of doctors work in public institutions with the remainder working between the private for profit (21%) and not for profit sector (11%). The majority of hospital doctors in France are full time salaried workers employed by the hospital.

There are some exceptions:

- Some doctors work part time in the hospital and have a private practice.
- Under certain circumstances private doctors can be contracted by public hospitals to deliver services.
- Some doctors who work full time in public hospitals can deliver services on a private basis.

Side Effects of Private Practice in Public Hospitals

According to Pascal Garel, a number of issues have been identified:

- Recruitment and retention of doctors. The right to practise privately was designed to attract doctors to work full time in hospitals.
- Controls are not efficient enough.
- Fees are too high.
- Consultations and procedures are in excess of what is legally allowed, sometimes without sanctions.
- Equality and equity of access to high quality care.
- Two tier system: medicine for the rich, medicine for the poor.

Regulation / Monitoring

Private practice by public sector doctors in France is limited and heavily regulated. The main rules covering private practice in public hospitals are as follows:

- A publicly employed doctor who wishes to have a private practice must sign a contract with the hospital which is valid for 5 years.
- Private activity must not exceed 20% of the statutory work time and the volume of services delivered privately must be lower than those delivered publicly.
- No bed or equipment can be dedicated to private practice and the activity must not create a burden on public sector colleagues.
- Public hospitals where private activity occurs must put in place a 'charter' outlining the principles guiding the practice which must highlight the rights of patients to be treated publicly.
- The hospital must have a private practice commission that monitors private activity of their employees and ensure compliance with the regulatory framework.
- Private services fees must be displayed and explained to patients and the patient must sign a clear consent form.
- Doctors must pay the hospital a regulated percentage of the fee received.

France – Background Information

Governance of the French social insurance system is centralised

The French financing system is based on social insurance, with a stronger role for the state than is usually the case in such systems. The responsibility for the management

of the health system is split between the state and social health insurance (SHI). Since the mid-1990s, reforms have devolved power from the national to the regional level, in particular for planning. Following the 2009 Hospital, Patients, Health and Territories (HPST) Act, most existing regional regulatory institutions were merged into single regional health agencies (Agences régionales de santé, ARS), to facilitate and spread national governance at a local level and ensure that health care provision meets the needs of the population.

Health spending per capita in France is 20% higher than the EU average

France ranked ninth among EU countries in health expenditure per capita in 2015 (EUR 3,342 per capita, adjusted for purchasing power parity). However, as a proportion of GDP, health spending in France was the second highest (after Germany) with 11.1% of GDP allocated to health. Health expenditure in France has grown at a moderate rate over the past decade. Nonetheless, because health spending has grown faster than the economy, the health spending share of GDP has increased by almost one percentage point since 2005.

Over three-quarters of total health expenditure is publicly funded (79%), primarily through social health insurance (SHI). SHI is mainly funded from income-based contributions from employers and tax payers. Additional revenues come from specific taxes, such as taxes on tobacco and alcohol and on pharmaceutical companies. Since 1996, SHI annual expenditure has been controlled by a national objective for health insurance expenditure (known as ONDAM).

Complementary (voluntary) health insurance plays an important role in France. It provides complementary insurance for co-payments and better coverage for medical goods and services poorly covered by SHI (e.g. eyeglasses and dental care). It finances approximately 14% of total health expenditure and covers about 95% of the population. Among those insured, one in ten is covered by a publicly funded complementary coverage known as 'Couverture maladie universelle complémentaire' (CMUC). The remaining out-of-pocket payments paid directly by patients account for only 7% of total health expenditure, the lowest share across EU countries and well below the EU average (15%).

Nearly all the population is covered by social health insurance

All legal residents are covered by SHI, an entitlement of the wider social security system. Set up in 1945, the SHI scheme initially offered coverage based on professional activity and was contingent on contributions. The scheme has always been administered by a number of non-competing health insurance funds catering to different segments of the labour market. The main fund (Caisse Nationale d'Assurance Maladie des Travailleurs Salariés, CNAMTS) covers 91% of the population. The two

other sizeable funds cover self-employed people (Régime Social des travailleurs Indépendants, RSI) and agricultural workers (Mutualité Sociale Agricole, MSA).

In 2000, the Universal Health Coverage (Couverture Maladie Universelle, CMU) Act changed the public insurance entitlement criterion from professional activity to residence. This allowed a small but growing share of the population to benefit from the same rights as the rest of the population. In 2016, this mechanism was generalised and simplified to become the Puma (Protection Universelle Maladie). Around 3.8% of the population now draw their social health insurance coverage from their residency status.

The benefits package is broad, but the depth of coverage varies by type of services

The French health care basket is relatively broad in terms of goods and services covered. Medical goods and services covered include hospital care and treatment delivered in public and private institutions, outpatient care provided by GPs, specialists, dentists and midwives and all other services prescribed by doctors (diagnostic and medical procedures, laboratory tests, pharmaceutical products, medical appliances and health care related transport).

However, the depth of coverage varies depending on the goods and services (Box 1). It is fairly limited for eyeglasses and contact lenses and dental prostheses, with a substantial part of the cost left to patients or their complementary health insurance. The SHI also does not cover extra-billing amounts over the statutory tariffs. Doctors practising in 'Sector 2' (the sector where fees are set freely) are allowed to set their fees at higher levels than the statutory tariffs under the social security system, and these higher fees have to be paid either by patients themselves or their complementary health insurance. To limit such extra-billing, some provisions were introduced in the global agreement between the public health insurance system and physicians' unions in October 2012, so that these Sector 2 doctors would be incentivised to sign a voluntary contract restraining these extra-billing practices. There are also small deductibles (€0.50-2.00, with an annual cap of €50), which are usually not covered by complementary health insurance, to reduce overconsumption and patient demand.

BOX 1.**PUBLIC COVERAGE FOR HOSPITAL CARE, OUTPATIENT CARE AND PHARMACEUTICALS**

The coverage rate for hospital care is generally 80%, but increases up to 100% in a number of cases (e.g. people with long-term conditions and maternity cases). Whatever the level of coverage, most patients must pay a flat-rate catering fee (*forfait journalier*) of €18 per day for hospital accommodation (this fee is expected to increase to €20 starting in 2018).

For outpatient care provided by self-employed health professionals, the coverage rate ranges from 70% of the statutory tariff for consultations with doctors and dentists to 60% for services provided by medical auxiliaries and laboratory tests. However, the coverage of a doctor's visit can vary according to the 'preferred doctor' scheme (set up to support coordinated care pathways). Under this scheme, patients are requested to register with the doctor of their choice (most often a general practitioner), whom they should see to obtain a referral to a specialist. The coverage rate of patients who directly access specialists (or other general practitioners) outside of the coordinated care pathways falls to 30%.

The coverage rate for pharmaceuticals is generally set at 65%, but it can range from 100% for non-substitutable or expensive drugs to 15% for drugs that have been assessed as having low effectiveness (based on *Service Médical Rendu*). Drugs to treat long term conditions are covered 100%

The geographic distribution of doctors and other health professionals is unequal

Even if the number of doctors per capita in France has remained relatively stable over the past 10 years, it is now slightly lower than the EU average (3.3 doctors per 1 000 population in France compared with 3.6 doctors for the EU average in 2015). The number of nurses per capita has increased and is now slightly higher than the EU average (9.9 nurses per 1 000 population in France compared with 8.4 for the EU average in 2015). However, there are wide disparities in the density of health professionals across regions in France, in particular for specialist doctors, with the density being two times greater in some regions than in others.

The number of hospital beds has been reduced, but remains above the EU average

The number of hospital beds in France declined by more than 15% in absolute terms since 2000, but still remains above the EU average (6.1 per 1 000 population in 2015 compared to 5.1 for the EU average). There has been a reduction in all types of beds. Acute care beds came down by 12.5%. The most substantial reduction was for long-term care beds in hospital. These declined by over 60% between 2000 and 2015 through their transformation into nursing homes, considered to be a more appropriate response to the needs of frail elderly populations. Psychiatric care beds also diminished (by over 8%) as a result of the French deinstitutionalisation policy and a reorientation towards more community-based mental health facilities.

The role of GPs in care coordination has been strengthened

Primary and secondary ambulatory care is provided mainly by self-employed doctors and medical auxiliaries (including nurses and physiotherapists) working in their own practices, and, to a lesser extent, by salaried staff working in health centres and hospitals. GPs have taken on a major role in the coordination of care through a semi-gatekeeping system (called 'the preferred doctor scheme'). This provides incentives to people to visit their GP prior to consulting a specialist.

Various initiatives have sought to address the lack of coordination and continuity of care in the health system. These include the gatekeeping structure developed under the 2004 Health Insurance Act to promote care coordination and provider networks to offer multidisciplinary care to patients with complex needs. Recently, care pathways have been developed for patients with chronic diseases and for patients over 75 years of age at risk of dependency. The 2016 Health Reform Law aims to develop some Territorial Hospital Groups to improve cooperation between hospitals within a defined geographic area.

This content is taken from:

OECD/European Observatory on Health Systems and Policies (2017), *France: Country Health Profile 2017, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

The full report can be accessed here: http://www.euro.who.int/__data/assets/pdf_file/0003/355980/Health-Profile-France-Eng.pdf?ua=1

Profile of the international experts

The following international experts presented an international comparison evidence briefing on private practice in public hospitals to the Review Group in Dublin, on 19 June 2018.

Thomas Czypionka (Institute for Advanced Studies, Vienna)

Dr. Thomas Czypionka is Senior Researcher and head of the Health Economics and Health Policy research group. He is both an economist and MD, and he has been leading applied research projects commissioned by Austrian stakeholders, the European commission, and the London School of Economics and Political Science, with a special focus on health services research, healthcare financing, and healthcare reform. Among several advisory commitments, he was expert advisor to the “Masterplan for Health” by Austrian Social Health Insurance as well as expert on the health reform commission to the chancellor in 2010. He currently heads the economic part of the initiative “future forum for oncology”. He also teaches at several universities.

Pascal Garel (European Hospital and Healthcare Federation – HOPE)

Since September 2005 Pascal has been Chief Executive of HOPE, the European Hospital and Healthcare Federation. HOPE gathers 36 national organisations from 30 European countries, covering around 80% of the hospital sector. For more than 20 years he has been actively involved in the mechanisms of decision-making in the hospital sector on various issues including research, hospital management, quality and patient safety development at the hospital level, in national, European and international contexts.

His main professional background is healthcare management, with twelve-years of experience in France in two Teaching Hospital Centres (Nantes and Rouen). Previous posts include director of the European and International Department of the French Hospital Federation and responsibilities for Central and Eastern Europe at the French Ministry of Health. Associated lecturer at the University Paris Dauphine, he also teaches at the Alexandria University Senghor and at the French National School of Public Health.

Educated in political science (*Institut d’Etudes Politiques de Paris*, 1986) and European law (University of Rennes, 1992), he became Hospital Manager in 1989 with the diploma of the French National School of Public Health.

Ian Brownwood (OECD)

Ian Brownwood coordinates the Health Care Quality and Outcomes programme at the Organisation for Economic Cooperation and Development. He and his team work with national experts from over 35 member and collaborating countries to develop and establish internationally comparable indicators of health care quality and facilitate information exchange on international experiences on effective system improvement strategies.

Ian has economic and nursing qualifications and has extensive experience working in both policy and clinical capacities in the health care sector. Before coming to the OECD, he worked for over two decades with regional health ministries in Australia focussing on strategic policy issues related to structural and funding reform and health system performance evaluation.

Staff of the European Observatory

The following staff of the European Observatory attended the international comparison evidence briefing on private practice in public hospitals to the Review Group in Dublin, on 19 June 2018

Matthias Wismar, Senior Health Policy Analyst

Matthias Wismar develops studies, policy briefs, rapid responses and face-to-face dissemination events including policy dialogues, evidence briefings, policy mappings, seminars, workshops and book launches on behalf of the European Observatory on Health Systems and Policies. His main areas of interest are health policy, politics and governance; civil society and health; European integration, health and health systems; the health workforce; and health in all policies.

He holds a doctorate in political science from Goethe University Frankfurt (Germany) and has also studied at the University of Southampton (United Kingdom) and Nuffield College, Oxford University (United Kingdom). Before joining the Observatory, he was heading a health policy research unit at Hanover Medical School (Germany).

Erica Richardson, Technical Officer

Erica is based at the London School of Hygiene and Tropical Medicine (LSHTM). As well as following health system developments in the United Kingdom, Erica has a particular brief for monitoring health systems in eastern Europe, the south Caucasus and central Asia, and is the Health Systems in Transition (HiT) editor for many countries in this region. Her research focuses on the development of health systems and health policy in the countries she covers, as well as equity issues. Erica joined

the Observatory team in October 2005 after working as a Research Fellow at both the University of Sheffield and the University of Birmingham, where she still holds an honorary post in the Centre for Russian, European and Eurasian Studies.

The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making through the comprehensive and rigorous analysis of the dynamics of health care systems in Europe and beyond. It is a partnership that includes national governments and other authorities (Austria, Belgium, Finland, Ireland, Norway, Slovenia, Sweden and the United Kingdom, the Veneto Region, the French Union of Health Insurance Funds), international organisations (the WHO Regional Office for Europe, European Commission, and World Bank) and academia (London School of Economics and Political Science, and London School of Hygiene & Tropical Medicine).

Appendix 8

SFI Research Professorship Programme

The Science Foundation Ireland (SFI) Research Professorship Programme⁹⁷ assists Ireland's Universities and Institutes of Technology in the recruitment of world-leading researchers for Professorial Chairs, or similar research leadership positions in targeted scientific, technology and engineering areas. The key purpose of the Research Professorship Programme is to:

1. Build research leadership capacity in key areas of economic importance in which there is a strategic imperative to either develop Ireland's proficiency or to build upon an existing strength;
2. Attract star international talent to establish their research activities within the Irish research system;
3. Leave a lasting legacy of trained Irish researchers who have learnt from leading international researchers;
4. Enhance the Irish research base in key innovation-focused areas that have the potential to yield future industrial development and job creation

The Research Professorship Programme operates on the basis of a partnership approach, whereby SFI provides the research funding, and the Universities provide the salary of the Research Professor and appropriate infrastructural facilities. Universities and companies worldwide are intensifying their focus to ensure that they are attractive destinations for internationally mobile research talent. The personal compensation that a star researcher can receive in many other countries (most notably in the USA, UK, Germany, Singapore and China) is higher than in Ireland. Moreover, government support schemes operated by a number of established and developing countries (e.g., Singapore, China, Russia, UAE, Saudi Arabia, etc.) also mean that star performers in STEM research are in constantly high demand. The impact of this highly competitive landscape on Ireland is crystallised by the difficulties that Irish universities are currently experiencing in attracting high-calibre targeted Professors and, even after an SFI Research Professorship funding award offer has been made, finalising employment contracts

The proposal sought a derogation from the existing salary cap of €185,000 to be recruited as part of SFI's Research Professorship Programme. In order to alleviate the difficulty in recruiting these Research Professors at the desired level in the targeted areas, and in recognition of the potential commercial benefits to Ireland from their

97 Source: Department of Education and Skills

work, up to 10 individuals recruited through the SFI programme may earn up to the maximum salary of €250,000 which applies to the commercial semi state sector, subject to the achievement of key performance criteria.

Department of Public Expenditure and Reform sanction was made on an exceptional basis in order to address the difficulties faced in recruiting high level research talent to Ireland through the SFI Research Professorship Programme. The scheme will apply only to individuals appointed through this programme, and will initially be limited to a maximum of 10 awardees at any one time. All cost must be met from within existing resource allocations.

