An tÚdarás Árachas Sláinte
The Health Insurance Authority

Removing private practice from public hospitals: Submission of the Health Insurance Authority to the de Buitleir Independent Review Group

February 2018

The Health Insurance Authority welcomes the invitation to make a submission to the Independent Review Group on removing private practice from public hospitals.

The Slaintecare report proposes substantial changes in Ireland's healthcare system and there is still considerable uncertainty concerning the detail of the implementation of the proposals and also the timing of their implementation. This uncertainty constrains what a public authority like the HIA can say about the proposals. Nevertheless, the HIA wishes to make as useful a contribution as is possible to the policy formation and implementation process in Irish healthcare and therefore some comments and assessments made in this submission are necessarily somewhat speculative. The HIA's submission is mostly confined to health insurance aspects of the proposed healthcare policy changes.

Legislative and legal issues related to health insurance

The original Health Insurance Act 1994 and associated Regulations were drafted in the healthcare context of very few private hospitals and an overwhelming proportion of private hospital treatment being provided in public hospitals and all consultants in public hospitals regularly treating both private and public patients. There has been a substantial change in the pattern of demand in the last ten years and now the majority of health insurance claims arise in private hospitals. While there have been regular amendments of the Health Insurance Act 1994, some of the associated Regulations have never been amended or only very limited amendments have been made.

A substantial review of the health insurance legislation and probable significant amendments will be required. A core concept in the legislation is "a health insurance contract" which has a specific legal definition. A "health insurance contract" implicitly assumes that private treatment in a hospital is available to the insured. As long as everyone covered by a health insurance contract is living near a public hospital that provides private treatment, this is largely the case, although it could be possible that private treatment is not actually available in certain specialities if all the consultants in particular specialities in a public hospital are on "Type A" contracts. Removing private practice from all public hospitals radically alters some of the basic assumptions (explicit and implicit) in the health insurance legislation. Health insurance customers might find themselves living 200 km from an appropriate range of available private treatment in a hospital and the question arises as to whether such treatment is reasonably "available" to them.

Most public hospital admissions, whether of public or private patients, are for acute emergency care and are admitted through the emergency department[1]. This most common occasion of hospital care will no longer be available as a private patient with the Slaintecare proposals, except in very limited circumstances in one or two private hospitals. Some aspects of the health insurance legislation and Regulations will need to reflect this substantially more limited availability of private care in hospital.

The insurance contracts offered by health insurers will have to be changed and insurers will also have to reconsider their offer in the context of general insurance legislation, the Central Bank Consumer Protection Code and advertising legislation. For instance, health insurers advertising and marketing might have to distinguish between the location of its audience within Ireland, given the limited geographic spread of private hospitals.

Recruitment and retention of personnel - Hospital Consultants

An important issue for the health insurance market and also for a possible review of the health insurance legislation is exactly what happens with hospital consultants. What range and degree of treatment capacity will be available in private hospitals in terms of consultants? Could a situation arise where there was effectively negligible availability of treatment capacity in private hospitals in some specialities? A significant detail will be whether some full-time public hospital consultants in the new "Slaintecare regime" would be able and willing to do private work in private hospitals after they had fulfilled their public hospital commitments.

A major and special category of treatment is maternity care. No private hospitals now offer private maternity care and there appears to be little prospect of this occurring in the medium term and therefore, there would be no private maternity hospital care after Slaintecare.

Current and future funding arrangements

The final outcome for demand for private hospital acute healthcare and associated demand for health insurance will depend to a considerable extent on the scale of increased funding for the public hospital system that is provided. There is little doubt that additional spending of at least €1bn per annum, and probably considerably more than that, would be required in the public hospital system to achieve the Slaintecare target waiting time of a maximum of 12 weeks for elective treatment in public hospitals. In addition, the Government would have to fund the loss to public hospitals of private patient income of approximately €600m per annum at current prices. Finally, the Slaintecare report itself emphasises the need for front-loading of spending and activity to achieve good progress in reducing the current waiting lists for treatment and consultation.

The following health insurance claims data may be of use to the Group.

Total healthcare benefit claims paid by open market insurers (VHI, Laya, Irish Life) (€m)

First Half 2015	939
Second Half 2015	1,040
First Half 2016	1,034
Second Half 2016	1,052
First Half 2017	1,023

[1] The HSE 2018 Service plan states that out of 635,000 acute (public) hospital in-patient discharges in 2017, 18% were maternity and of the remaining discharges, 82% were emergency and 18% elective.

In addition, total claims paid by the three main restricted membership undertakings (Garda Medical, Prison Officers and ESB Fund) in 2016 would have been close to €100m, of which possibly over 80% would have been paid to hospitals and consultants. (These figures are estimates as the HIA does not receive claims data from the restricted undertakings.)

The HIA also receives more detailed data on claim payments by the open market insurers, which allows an approximate breakdown of the payments by healthcare provider, as follows for 2016 payments;

2016	%
Outpatients	7%
Private Hospitals	44%
Public Hospitals	30%
Consultants	19%

The table above shows that 93% of insurance claim payments in 2016 are for treatment in a hospital, whether public or private. Most episodes of treatment give rise to a double claim, one for the hospital where the treatment takes place and one for the consultant treating the patient. Therefore the 19% of claims paid to consultants referred to in the table above is entirely for treatment of patients who have been admitted to a public or private hospital, either as an in-patient or for a day-case or "side-room" procedure. A large majority of the public hospital claim payments by value (including associated payments to consultants) arise due to emergency admissions of private patients. Claims paid by insurance companies for attendances at consultants' clinics are included in "outpatients" in the above table. Outpatient claims also include claim payments by insurance companies for consultation/treatment by general practitioners and other healthcare professionals like physiotherapists and for scans carried out by radiographers in clinics/centres other than hospitals.

Policy implications for health insurance

Both the roles of private hospitals and health insurance in Irish healthcare require major policy reviews before the main Slaintecare proposals are commenced.

The last substantial statement of public policy concerning the role of health insurance in Irish healthcare was the White Paper on health insurance, published in 1999. Since then, successive Governments have continued to support the role of health insurance as a minor but significant source of funding for (primarily) hospital care. A regulatory regime is in place to support community rating in health insurance, which undoubtedly contributes to the relatively largescale take-up of voluntary health insurance in Ireland. Most notably, the risk equalisation scheme was introduced to support community rating in the last decade. Ireland's health insurance system now has a primarily supplementary role in healthcare funding, given that all residents in the State are entitled to equal access to all public health services[2] and especially to all public hospitals.

Since the publication of the White Paper in 1999, there has been a trend to a greater proportion of claims arising in private hospitals, with significant additions in private hospital capacity during the

[2] The two thirds of the population without medical cards are required to pay €80 per night in a public hospital up to an annual maximum of €800.

last 20 years. That trend was reversed somewhat since 2014 because of the restructuring of charges for private patients in public hospitals where all private patients are now required to pay a daily charge, which is usually €813.

The Government needs to consider whether an explicit role is desirable for the private hospital sector (including suitable availability of hospital consultants) in healthcare policy to augment public sector provision of acute hospital services[3]. The Slaintecare report is largely silent on this issue.

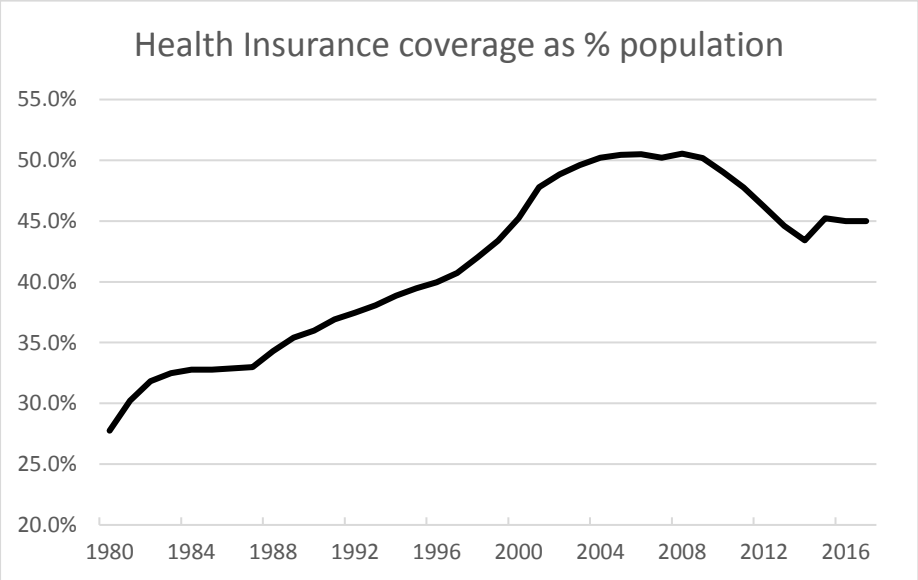
A related issue to be considered is what scale of increase in annual funding will be actually allocated to the public health system, especially to the public hospital system, and what scale of expansion of public hospital bed and operating theatre capacity will be implemented.

Future healthcare policy towards private hospitals and health insurance are interlinked and need to be considered together. Dependant on overall policy considerations for private hospital care and the health insurance market, the Minister and the Government might wish to reconsider some key principles in Irish health insurance legislation.

The ESRI and others have forecasted that there will be a very large increase in demand for capacity in residential nursing homes, in view of the expected ageing of the population. Other social trends (e.g. smaller families) will also contribute to this trend. In view of the large cost of nursing home care if paid for privately (approximately €60,000 per annum in Ireland), there is a theoretical case for an insurance market to fund this potential large cost. However, there are practically no examples in the world of significant private insurance funding for nursing home costs. In Ireland, the sector is dominated by the publicly funded "Fair Deal" scheme.

Timeframe and phasing

The detail of the implementation of the Slaintecare proposals are likely to have substantial implications for the health insurance market, especially the phasing of particular measures.



Sources: White Paper on Health Insurance 1999, HIA data.

[3] There are 2,468 in-patient and 581 day-case beds in the private hospital sector (2016 data). There are also a number of private scan/radiography centres. All of the health insurers have comprehensive lists of hospitals in the state, both public and private, in their policy documentation and these lists are available on their websites.

Two scenarios for the health insurance market

The HIA considers that there are two reasonable scenarios in the health insurance market, which are probably dependant in turn on alternative scenarios associated with the implementation of Slaintecare.

Following the implementation of the Slaintecare proposals, the proportion of the population with health insurance could enter structural decline from the current level of 45%, albeit a gradual one. While it is quite unlikely that the proportion of the population with health insurance would decline to UK levels (where less than 10% of the population have an equivalent type of cover to that in Ireland), it is very possible that it would decline over a 15 year period towards 30% and possibly below. Any such possible decline would be led undoubtedly by younger adult age cohorts, who are responsible for only a small proportion of health insurance claims, which would result in higher premiums on average and the risk that higher premiums would lead to even more relatively healthy people dropping health insurance and consequent further increases in premiums.

The hospital healthcare scenario that might well lead to a structural decline in the health insurance market would be one primarily where waiting times for elective care in public hospitals were reduced to the Slaintecare 12 week target, within a relatively short timeframe and many people, especially younger adults might not see the need to have private health insurance. To achieve such an outcome, recent evidence from the President of the Irish Hospitals Consultants Association, research published by the ESRI and from a future-orientated report by the Royal College of Physicians all point to a requirement that the public hospital system would need an increase in operational capacity/capability of the order of 20% to 25% in order to service almost all of the combined need for emergency and public elective surgical hospital care in terms of beds, operating theatres, surgeons and anaesthetists, nursing and other related staff. Front loading of spending and surgical activity would also be required to achieve a major reduction in waiting times within a reasonable space of time.

An alternative scenario for health insurance is also quite possible. Waiting times for elective procedures in public hospitals might continue to be quite long, probably because future Governments don't increase spending and resources in public hospitals by sufficiently large amounts to achieve short waiting times for elective procedures or significant increases in public hospital capacity might be delayed. Or possibly, there may not be enough clinical human resources in public hospitals to achieve a sufficiently large increase in elective treatment in public hospitals. This would be likely associated with a continued pattern of demand for health insurance similar to currently and would probably result in the proportion of the population with health insurance remaining broadly where it is at present; that is, between 40% and 50% of the population. The value of health insurance claims would be significantly less relative to total healthcare spending than at present because no activity in public hospitals would be reimbursed by insurers. (In 2016, 41% of hospital claims by value were in public hospitals.) In this scenario, the private hospital sector might see an opportunity to substantially expand the range of services they offer, thus easing some of the demands on the public system. However the constraints previously mentioned (specialist consultant availability and cost of professional negligence insurance) would need to be overcome. Additionally, without specific policy interventions, any such expansion is likely to be selective in terms of both the range of services added and the locations where they are made available.

It should be noted that the beginning of any possible structural decline in the proportion of the population with health insurance would be dependent on the clear commencement of Slaintecare changes and an associated publicly visible rapid reduction in waiting times for elective treatment in

public hospitals. In the absence of major changes in the current pattern of hospital care in Ireland, as in Slaintecare implementation, the current trends of demand for health insurance suggest that the market will continue to grow broadly in line with trends in the economy.

Operational matters including specialist services

Another significant factor that would influence the long term trend in the health insurance market is the future capacity and range of competence for elective hospital care in private hospitals. The biggest issue here would be whether there would be sufficient consultants available for private hospital practice in a wide range of specialities and in sufficient numbers to ensure quite short waiting times for almost all private elective surgical procedures. Given the relatively limited overall availability of suitably qualified and experienced consultants in many specialities in Ireland, it is quite possible that if the Government devoted the resources to ensuring a substantial increase in public hospital availability of consultants, this might well negatively impact on the availability of consultant person hours in private hospitals.

Conclusions

From the health insurance perspective, there are two major uncertainties concerning the implementation of the Slaintecare proposals; the scale of increased funding and resources that will be provided to the public hospital system and the precise terms of employment and staffing levels of consultants in public hospitals.

In the context of what current and future Governments do regarding public hospital funding and consultants, Government might well consider reviewing healthcare policy as regards both private hospitals and private health insurance.

The Government and the Oireachtas also need to consider the principles and the detail of the Health Insurance Acts 1994 to 2016 in the context of the implementation of Slaintecare.