Chapter 37 Health Service Executive

Management of Private Patient Income

Management of Private Patient Income

37.1 Under longstanding arrangements Irish public hospitals treat a certain number of private patients. As a result, charges are payable by those patients to the hospitals for their accommodation and to the consultants in respect of their fees. Over 50% of the population are covered by private health insurance. Consequently, much of the income from private patients is recovered by the hospitals from private health insurers.

Treatment Policy

While Irish public hospitals treat private patients, the core purpose of the public hospital system is to provide services for public patients. All persons ordinarily resident in Ireland have full eligibility for hospital services. The fact that a person may have private health insurance does not take away from his/her eligibility for services as a public patient. Government policy has been to ensure that there is equitable access for public patients, that the proportion of private activity is appropriately controlled and, as far as possible, additional resources provided benefit public patients in the first instance.

37.2 In order to control the level of private activity in publicly funded hospitals, with a view to ensuring equitable access for public patients, a system of bed designation was introduced by regulation in 1991[119]. Under this system all beds were designated as private or public or were declared to be non-designated[120]. In broad terms, the Regulations were intended to ensure that, as far as possible, private patients were only accommodated in private beds. A consequence was that only beds designated as private were reckoned by private insurers in refunding the cost of maintenance of patients in hospitals. The designation process led to approximately 20% of beds being designated as private but with varying levels of private bed designation in individual hospitals.

Regulation of Public : Private Activity

The Health Services (In-patient) Regulations, 1991 provide that no private patient being admitted as an in-patient to a hospital as an elective (i.e. non-emergency) admission should be accommodated in a designated public bed. Conversely, a public patient being admitted in similar circumstances should not be accommodated in a designated private bed. This rule does not apply in the case of an emergency admission.

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119 S.I. No. 135/1991 – Health Services (In-patient) Regulations, 1991.

120 Non-designated beds generally refer to critical care (e.g. Intensive Care Units, Coronary Care Units).

Audit Focus

The audit sought to examine

- the extent to which private patients are treated in public hospitals and whether all private patients were being charged for accommodation by hospitals in circumstances where they had a private treatment relationship with their consultant
- whether the full economic cost was being levied on private patients
- whether Consultant Contract 2008 will impact on the recovery of accommodation charges by hospitals in respect of private patients
- the timeliness of debt recovery by hospitals in the public health system.

Extent of Private Patient Treatment

37.3 In the course of the audit, data relating to in-patient private and public bed usage in 24 hospitals was examined for 2008. The results are set out in Figure 126.

Figure 126 Comparison of In-Patient Categories and Accommodation Provided[a]

	Public Patients	Private Patients	Total
Patient Classification	1,315,441	408,267	1,723,708
Patient Accommodation			
Public Beds	1,149,740	183,848	1,333,588
Private Beds	83,541	203,064	286,605
Non-Designated Beds	82,160	21,355	103,515

Note:

a All figures quoted are expressed in bed-days.

37.4 45% of all private in-patient throughput was not the subject of a maintenance charge because the patient was accommodated in a designated public bed and a further 5% was not charged for 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.

37.5 On the other hand, accommodation designated for private patients was used to the extent of 83,541 bed-days to accommodate public patients. In these cases, from a financial management viewpoint, the overall effect is that the hospital system has foregone the potential income from private patients in return for the use of these resources to provide services to public patients.

37.6 Bed-days in the 24 hospitals examined represent about 46% of the total in-patient bed-days in the public hospital system. While the data pertains only to those hospitals whose information systems were capable of producing the required analysis it appears to be reasonably indicative of the throughput within the system.

37.7 In 2008, 124,000 (20%) of day cases were private patients. As with in-patients, the hospitals are only entitled to a maintenance charge if the private day patient occupies a designated private bed. No analysis of public : private bed usage was available in respect of day cases so it is not possible to determine the percentage of cases for which the hospitals did not receive a fee.

Conclusions – Charging for Private Patients

50% of in-patients who are treated privately in the 24 hospitals reviewed are not charged for their maintenance.

Cost Recovery by Hospitals

37.8 Maintenance charges levied by the HSE in respect of patients treated in designated private beds are determined by the Minister for Health and Children. The rates are usually revised on an annual basis and over the past few years the percentage increases have been significantly more than the rate of inflation. The 2008 rates are set out in Figure 127 below.

Figure 127 Charges for Private Maintenance

Accommodation	Maintenance Category	Regional[a]	County[b]	District
		2008	2008	2008
		€	€	€
Private	A	758	506	217
Semi-private	B	594	407	185
Day Care	C	546	362	161

Notes:

a HSE Regional Hospitals, Voluntary and Joint Board Teaching Hospitals.

b HSE County Hospitals and Voluntary Non-teaching Hospitals.

37.9 The rates do not cover the full economic cost to the public hospital but increases over the past few years have reduced the gap. The HSE has calculated the 2009 average daily cost for category A maintenance at €1,018 for in-patient cases and €733 for day cases and category B at €913 for in-patient cases and €885 for day cases[121]. No costings were available for category C as of July 2009.

37.10 The examination did not seek to verify these costings as work is ongoing as part of a detailed study of the economic cost of private and semi-private accommodation in public hospitals under an independently chaired Steering Group set up by the Department.

Conclusions – Cost Recovery

The full economic cost of maintenance is not being levied. However, there has been an increase in recent years in the proportion of that cost recovered and fees have been substantially increased in 2009. The Department has set up a group to establish the most appropriate way of charging the economic cost of providing services to private patients in public hospitals.

[121] Key assumptions made in calculating these estimated costs for 2009 are – inflation adjusted 2007 costs are used in calculating the average cost per bed day. This is the latest full year for which data is available. There is no capital or depreciation costs in the 2007 base calculation. A capital cost of 5% is assumed and included in the estimated 2009 cost.

Factors Influencing Charging

37.11 The public hospital system only claims accommodation charges for patients who occupied designated private beds. Where a patient occupies a public bed, despite having opted for private consultant services, the hospital may not charge for that accommodation. As indicated in Figure 126, a proportion of public patients are accommodated in designated private beds.

Views of the Accounting Officer of the HSE

37.12 The Accounting Officer stated that the capacity of the health service to charge for maintenance of private patients was constrained by the factors outlined above and hospitals managed those constraints in the following manner

- Where a patient is accommodated in a public bed but is private to the consultant, hospitals in these instances can only claim accommodation charges for the time in which the designated private bed is occupied by the private patient. However, every effort is made to ensure that where a patient elects to go private then designated private accommodation is allocated to them at the earliest available opportunity.
- The overriding consideration in the treatment of any patient is the appropriate clinical care and, in some instances, whatever the patient's designation, the appropriate clinical care demands isolation in a single room, particularly in the case of Infection Control patients. The availability of single rooms as isolation facilities is an important factor in tackling the serious threat posed to patient safety by Health Care Acquired Infections (HCAIs), including MRSA, in acute hospital settings. Consequently, private rooms are used for public patients in a proportion of cases. For this reason, in 2007 the Minister for Health and Children directed that designated private beds should be used where isolation facilities are required for patients who contract HCAI. In practice, a designated private bed would only be used where an isolation facility is required for a patient with a HCAI and another isolation facility is not available.
- In certain cases of care – a specific example would be where a patient admitted to a Coronary Care Unit (non-designated bed) opts to avail of private consultant physician services and the hospital facilitates this arrangement in accordance with the patient's wishes – the hospital would not be in a position to claim private accommodation charges in this case. The policy rationale for non-designated beds is that accommodation for persons who are very acutely ill or where a national specialty is concerned should not be differentiated. This was done to ensure that it is solely clinical factors that determine which patients are accommodated in those facilities.

37.13 In regard to the on-the-ground bed management decisions the Accounting Officer informed me that, in the larger hospitals, bed management was carried out by staff dedicated to that function and, out of hours, by nurse management. Bed management processes took into consideration that private patients might only occupy public beds in the restricted circumstances provided for in the Regulations.

37.14 In regard to the fact that at current admission rates, the bed designation system could not ensure that all private patients are charged a maintenance charge by the hospital in which they are treated, the Accounting Officer pointed out that the designation of private beds in public hospitals was a matter of Government policy and was based on the Government's objective of ensuring equitable access for public patients.

37.15 The Accounting Officer stated that since the designation of beds was last reviewed in the 1990s, hundreds of new beds had been provided in public hospitals but they had not been formally designated as either public or private beds. Many of these beds were in private or semi-private

rooms, and were, therefore, potentially suitable for designation as private beds. However, since they had not been so designated, private health insurers did not accept maintenance charges in respect of private patients occupying them. While no maintenance fee was chargeable for insured patients who were not accommodated in one of the designated rooms or beds, fees were claimable by the consultants treating those patients.

37.16 At the same time, with the increasing use of designated private rooms to accommodate public patients, for infection control reasons, there was a further loss of private patient income to the public hospitals.

37.17 The Accounting Officer said he would welcome a review of the bed designation arrangements, regardless of whether the overall number of private patient beds was altered or not. He informed me that the HSE was now in correspondence with the Department of Health and Children with a view to achieving greater flexibility in the operation of the bed designation arrangements, so as to try to mitigate this loss of potential income.

Views of the Accounting Officer of the Department

37.18 The Accounting Officer of the Department has pointed out that Action No. 88 in the 2001 Health Strategy[122] provided as follows

'*All of the extra acute hospital capacity within the public sector, both in-patient beds and day beds, will be designated for use by public patients. The only exceptions will be Intensive Care Units, Coronary Care Units and other specialised beds which will continue to be non-designated. The provision of additional beds announced in this Strategy will be a significant step forward in ensuring that the needs of public patients are adequately met*'.

37.19 Accordingly, the Minister had not considered it appropriate to increase the number of beds – whether existing or new – in public hospitals designated for the use of private patients.

37.20 The standard of much of the newer ward accommodation and the need to combat HCAIs is such that the trend was increasingly towards provision of single rooms for public as well as private patients.

37.21 Since the publication of a White Paper on Private Health Insurance in 1999, Government policy had been to move towards charging the full economic costs for the use of public facilities and services for private patients, while being sensitive to the need for continuing stability in the private health insurance market and wider inflation concerns. This policy had seen significant increases in private charges in recent years, including a 20% increase introduced in 2009. These charges were in addition to the public hospital statutory in-patient charge, which currently stood at €75 in respect of each day during which a person was maintained. The maximum payment in respect of the statutory charge in any twelve consecutive months was €750.

[122] Quality and Fairness – a Health System for You.

Conclusions – Factors Constraining Cost Recovery

The objectives of ensuring equitable access and optimising the recovery of the cost of maintenance of all privately treated patients are difficult to achieve simultaneously within the present system.

The principal factor impacting on the recovery of maintenance costs of private patients is the fact that the designated beds system that is operated limits the extent to which maintenance charges can be recovered, even for patients who pay their consultants on a private fee basis for treatment charges. As will be seen from the next section the category of the primary consultant clinician is also relevant to the potential of the health system to levy charges for private patient maintenance.

Impact of New Consultants Contract

37.22 In March 2009 the Department of Health and Children clarified that a patient may only be regarded as having private status where he/she opts to avail of private consultant services rather than public consultant services under the Health Acts. The relationship of the patient to the consultant in this regard is a private matter for the individuals concerned.

37.23 Under the Consultant Contract 2008 certain consultants do not have any private practice in public hospitals (Category A consultants). The Department of Health and Children has confirmed to the HSE that patients of these consultants are public patients.

37.24 The HSE had assumed initially that maintenance charges would be payable to it in respect of patients with private insurance, accommodated in designated private beds and treated by a Category A consultant. The HSE believes that the fact that patients treated by Category A consultants will now be considered to be public patients is likely to lead to a loss of patient income.

37.25 Theoretically, it is possible for the HSE not to suffer any loss of income if hospitals can ensure that the rooms designated as private are only occupied by private patients under the care of a non-Category A consultant. In practice, however, this additional complicating factor in deciding bed allocation is likely to lead to income loss.

37.26 A second aspect of the new contract that may have consequences for bed designation is the provision that the volume of private practice that a non-Category A consultant may carry out in a public hospital is capped at a percentage of patient throughput adjusted for complexity through the medium of the casemix system[123]. This is a more sophisticated measure of private activity than one which relies on discharges or bed usage. It will require a detailed reporting system, which the HSE is currently putting in place (See Chapter 38). It remains to be seen how this approach to controlling private activity will operate in practice but it seems likely that adjustments to a consultant's public : private mix required under this system will prove a further complicating factor in managing bed utilisation.

Views of the Accounting Officer of the Department

37.27 The Accounting Officer stated that the Minister's intention was that the introduction of the Category A consultant grade should improve access for public patients to consultant services. The Department did not accept that the quantum of private accommodation income would be materially affected by the introduction of the Category A grade. In order for such a reduction to

[123] Casemix is a system which takes account of the varying complexity of medical procedures by converting them into comparable standard units of care.

occur, private beds in public hospitals would have to remain unoccupied by private patients for a significant part of the year. The Department stated that it had asked for, and was awaiting, evidence from the HSE to support this suggestion but maintained that the data in Figure 126 would suggest that this was unlikely to be the case.

37.28 In regard to the view that the casemix-weighted system for measuring consultants' public : private mix under the new contract will prove a further 'complicating factor' in managing bed utilisation, the Accounting Officer stated that the core principle was, save in certain permitted circumstances, that private patients might be accommodated only in designated private beds. This remained in force and the new measurement system provided an additional lever to help the HSE achieve the core public policy objective of improving access for public patients to public hospitals.

Conclusions – Consultant Classification

The arrangements for determining the relationship with the primary consultant are likely to impact on the potential private patient income recoverable by hospitals. It is difficult to quantify the financial effect at this point. However, 37% of all consultants who had opted for Consultant Contract 2008 are Category A consultants who work solely for the public hospital and are remunerated entirely by way of salary.

Timeliness of Debt Recovery

Audit Concern

At 31 December 2008, the total amount due to the HSE and the Voluntary Hospitals in respect of maintenance charges from private health insurers was €164 million of which €87 million was due to the HSE and €77 million to the Voluntary Hospitals. Many of these charges were outstanding for a considerable period of time.

The audit sought to determine the cause of the delay in collection.

Claim Procedures

37.29 Under current procedures the hospitals are required to submit to the insurers a completed claim signed by the patient's 'Primary Consultant Clinician' who is the consultant responsible for the care of the patient during their stay in hospital.

37.30 Each claim details the treatment provided, the length of stay in hospital and the costs which include the Primary Consultant Clinician's fee, the fees of any other consultants who treated the patient in hospital ('secondary consultants') and the maintenance and diagnostic charges. If any of the consultants, for whatever reason, delays submitting their paperwork to the hospital administration then the entire claim including that for the patient's maintenance is delayed and cannot be processed.

37.31 All of the administrative cost involved in processing the claim are borne by the hospitals even though a significant portion of any claim pertains to the recovery of fees that accrue to the consultant. The hospitals also, in some cases, process claims in respect of consultants' fees even when no maintenance charge is payable as a result of the patient not being accommodated in a designated private bed.

Amounts owed to the HSE and Voluntary Hospitals

37.32 Over the years, the requirement to obtain confirmation from the Primary Consultant Clinician has given rise to significant delays in the collection of maintenance charges from insurers. Figure 128 illustrates the debt outstanding at 31 December 2008 and the average number of months income it represents for the larger HSE hospitals.

Figure 128 Debt Outstanding for Larger HSE Hospitals at 31 December 2008

Hospital	Due at Year End	Income of the Year	Debtors
	€m	€m	Months
Waterford Regional	12.2	13.2	11.1
Sligo General	6.3	7.6	10.0
Cork University	9.5	17.8	6.4
UCH Galway	11.0	21.8	6.0
Limerick Regional	8.8	18.2	5.8
Our Lady of Lourdes Drogheda	6.6	13.9	5.7
Unified Maternity	2.1	8.5	2.9
All HSE Hospitals	**87.0**	**170.8**	**6.1**

37.33 Figure 129 sets out the corresponding information for voluntary hospitals.

Figure 129 Debt Outstanding for Larger Voluntary Hospitals at 31 December 2008

Hospital	Due at Year End	Income of the Year	Debtors
	€m	€m	Months
Mater Misericordiae	8.7	8.8	11.8
AMNCH – Tallaght	15.5	23.8	7.8
Beaumont	10.1	15.8	7.7
St James's[a]	13.6	22.2	7.3
South Infirmary	3.5	10.3	4.1
Holles Street	3.2	10.0	3.8
Mercy University	4.1	13.2	3.7
All Voluntary Hospitals	**77.1**	**153.5**	**6.0**

Note:

a As a result of the introduction of electronic processing of claims piloted in St. James's Hospital, the period of credit has subsequently reduced to 65 days.

Reasons for the Delays

37.34 The Accounting Officer informed me that there were two main factors which caused delays in the processing of private health insurance claims and the subsequent payment process. These two factors were

- the entire process continues to be paper based and

- delay in obtaining sign off by some of the individual primary consultants.

37.35 Private insurance providers require that all insurance claims submitted for payment be signed by the primary treating consultant. From an administrative perspective, this involves staff locating all documentation (averaging 10 documents per claim) in relation to each claim, collating this documentation and arranging for appropriate sign off and submission to the private insurer.

37.36 The current administrative process is designed to facilitate the claiming of accommodation charges and clinical fees from the private insurance providers. The entire claim must be signed by the primary treating consultant before any part of the claim will be paid. Hospitals would be able to submit their claims for private patient accommodation immediately if they were not required to collate them with the consultant fees and medical data.

37.37 The Accounting Officer of the HSE informed me that there were sometimes difficulties in obtaining the required sign off by the primary consultant in each individual case. These difficulties varied considerably as between hospitals, depending on the willingness of individual consultants to sign off their own claim forms promptly.

Performance of Specific Hospitals

37.38 In regard to the hospitals with the greatest delays, the Accounting Officer said that there are recurring themes in the explanations received from these hospitals for delays in processing claims and receiving payment from the private insurance providers. In general, they pointed to the nature of the process, the requirements of the private health insurers, the delays by consultants in signing and the fact that a hospital's systems may not capture information in a way that supports efficient completion of the claims.

37.39 He assured me that each of the hospitals was taking action to improve speed of collection. In some cases additional resources were being allocated to deal with the issue. In others, the hospitals had reviewed the process to see what could be done to make it more efficient.

Addressing Claim Delays

37.40 The Accounting Officer also said that the HSE has been aware of difficulties with regard to collection times for private insurance claims and has been focused on improvements in this area over a period of time. The Minister for Health and Children recently met with the largest insurance provider and the HSE and secured agreement to an advance payment of €50 million to the HSE for 2009 for work already undertaken, as well as an agreement to work together to improve the processing of private insurance claims generally. This advance payment is for a time-limited period to allow for work to achieve improved performance in this area.

37.41 In November 2008 the HSE established a small high level working group to liaise directly with private health insurers on behalf of all public hospitals in relation to the following matters

- streamlining transaction processes and data exchange
- parameters for private and semi-private charges by public hospitals both voluntary and statutory
- billing and payment methods
- implications of Consultant Contract 2008
- the level of debt outstanding
- administration of Private Insurance claims process

- administration of premium deductions from payroll in the HSE.

37.42 This high level group which is representative of both HSE and voluntary hospitals and is chaired by a Hospital Network Manager has, at this stage, met with the largest private health insurers and with senior officials from the Department in relation to the designation of beds in the public hospital system. This group has secured agreement with the insurers for the sign off of claim forms by a secondary clinical consultant or clinical director after a period of 90 days, in the event of the hospitals being unable to obtain sign off by the original primary consultant. This is an interim measure and will be reviewed as agreements relating to the overall business processes progress.

37.43 In addition to the above, the HSE has now appointed a specialist group of finance and hospital representatives to visit each individual hospital with a view to implementing improvements in business processes in this area.

37.44 Hospital managers have been instructed that it is a requirement that they initially seek to achieve a maximum period of credit of 60 days in the short-term and improve this situation further in the longer term. Appropriate sanctions will be implemented to ensure that these targets are achieved.

37.45 The Accounting Officer also said that the HSE is separately examining the totality of its income collection process and further improvements which can be made in that area by the introduction of a shared services National Credit Management facility based in Kilkenny. The proposals for this facility are at an advanced stage and a comprehensive business case has been submitted to the Department of Finance for approval. Subject to formal approval, the HSE is now in a position to proceed to tender.

Electronic Preparation of Claims

37.46 The Accounting Officer expressed the view that an electronic claims preparation process could play a big part in improving collection times. An electronic claims preparation process had already been piloted in St. James's Hospital. Based on the results of the pilot, the Accounting Officer believes that a similar process could bring immediate reductions of 20% in the administrative overhead associated with claims preparation. It could also bring an immediate reduction in debtor days to all of the acute hospitals in the public hospital system. In addition, the streamlining and automation of the process would result in better data compliance, improved records retention, improved document management processes and reductions in storage space.

37.47 The HSE has submitted a business case to the Department of Health and Children for the introduction of an electronic solution along the lines piloted in St James's Hospital.

Alternative Claims Mechanism

37.48 In regard to whether it would be possible to decouple the HSE's claims for maintenance charges from the consultants' claims for their private fees, the Accounting Officer stated that this would be the HSE's preferred solution. However, he recognised that there had been a longstanding practice of the provision of this administrative service to the consultants. In addition, the HSE had been informed by the insurers that their regulatory bodies require medical sign off before any private insurance claim can be paid and that this is a standard requirement of the private medical insurance industry. However, in the event that agreement with the insurers on improvements to the claims process cannot be reached, the HSE will consider submitting accommodation claims together with medical discharge summaries and demand payment for the accommodation charges.

37.49 In that event, the HSE would continue to process the private bills from the consultants when they are received in the normal way, notwithstanding the fact that there is no contractual obligation on the HSE or the voluntary hospitals to provide administrative assistance to consultants in the processing of their private fee claims.

Conclusions – Timeliness of Debt Collection

Collection of private patient debts on a timely basis continues to be a problem for the HSE. The interim measures taken and the proposed electronic claim preparation system could help. However, the significant differences between hospitals in terms of collection times suggests that more could be done to share best practice within the system.

Overall Conclusions

The low rate of income recovery from patients who were treated privately in the hospitals reviewed would suggest that the State is facilitating private medicine without getting the related income for the service it provides.

Overall, a mismatch exists between the number of patients who present as private patients, the number who are treated as private patients and the number of privately treated patients whose accommodation costs are recoverable by hospitals. A more streamlined set of business processes is desirable so that each business stream is more closely aligned with its funding source and services billed accordingly.

Overall, the audit results suggest that

- Where private patients are charged for accommodation by hospitals, there are substantial delays in collecting debts from insurers. The delays are due to
  - outmoded administration systems
  - delays in sign off by consultants.
- 50% of private in-patients are not charged for their accommodation.
- Hospitals cannot charge for those patients that have private insurance and are accommodated in a private bed but are treated by Category A consultants.
- Finally, the rates charged do not represent the economic cost.