

## 16 Control of private patient activity in acute public hospitals

- 16.1** Public hospitals treat both public and private patients. While a sizeable majority of the Health Service Executive's (HSE) income to fund hospitals is in the form of a grant from the Exchequer, income is also derived from the collection of private patient charges. The HSE received €305 million in 2017 from such charges. Further private patient income was received directly by HSE-funded section 38 hospitals.<sup>1</sup>
- 16.2** A key goal of the HSE is to provide fair, equitable and timely access to quality, safe health services that people need. To achieve this, the HSE must ensure that income generating private activity within a public hospital does not undermine the principle of equitable access.
- 16.3** The contracts under which medical consultants are employed in HSE funded hospitals limit the extent to which they can engage in the provision of private care. Different limits apply, depending on the contract type.
- 16.4** This report considers
- how the HSE controls the level of private activity in public hospitals across the acute system from a national level down to individual consultant level
  - whether the HSE's performance measure meets the key criteria of a good performance measure.<sup>2</sup>

<sup>1</sup> Under Section 38 of the Health Act 2004, the HSE may enter into an arrangement with a body for the provision of health and personal social services on behalf of the HSE; the employees of such a body are public servants.

<sup>2</sup> The key criteria of a good performance measure are summarised in Figure 16.9.

### National activity

- 16.5** Overall, the HSE seeks to limit private treatment activity in Irish public hospitals to 20%. The HSE uses information contained in the Hospital Inpatient Enquiry (HIPE) system to monitor the level of private activity.
- 16.6** As shown in Figure 16.1, acute public hospitals' activities fall within four broad categories that involve medical consultants.

**Figure 16.1 Acute public hospital activity, 2017**

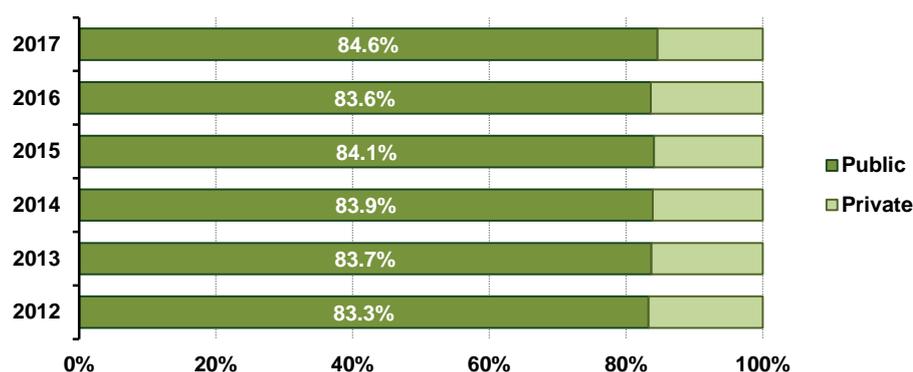
Type	Detail	Number	Activity	Recorded on HIPE
<b>Inpatient</b>	Patient admitted to hospital for treatment or investigation and scheduled to stay for at least one night in hospital.	635,802	Public and private	✓
<b>Day cases</b>	Patient admitted for a medical procedure or surgery in the morning and discharged before the evening.	1,054,659	Public and private	✓
<b>Emergency department attendances</b>	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.	1,416,449	Public only <sup>a</sup>	*
<b>Outpatient attendances</b>	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.	3,303,921 <sup>b</sup>	Public only <sup>a</sup>	*
<b>Total</b>		<b>6,410,831</b>		

Source: Health Service Executive Performance Report January 2018

Notes: a The consultants' contract provides that consultants shall not charge private fees in respect of patients attending emergency departments or public outpatient services in public hospitals.

b Includes attendances that occurred in a health or primary care centre.

**16.7** HIPE was developed to collect information about inpatient and day cases. Information captured in HIPE on public/private status refers to whether the patient was attended by a consultant on a private or public basis. The rate of public activity in acute public hospitals between 2012 and 2017 was around 84% on average (see Figure 16.2).

**Figure 16.2 Acute public hospital discharges, 2012 to 2017**

Source: HSE's Hospital Inpatient Enquiry System

### **Well-defined**

**16.8** The public/private measure is based on weighted units of an episode of treatment counted at the point of discharge from hospital. This is done by calculating the ratio of private to public patients treated where each case is adjusted for complexity, length of stay and a medical consultants contribution to the case.<sup>1</sup> It does not record non-clinical activities or the actual time spent by a medical consultant on the care of an individual patient.

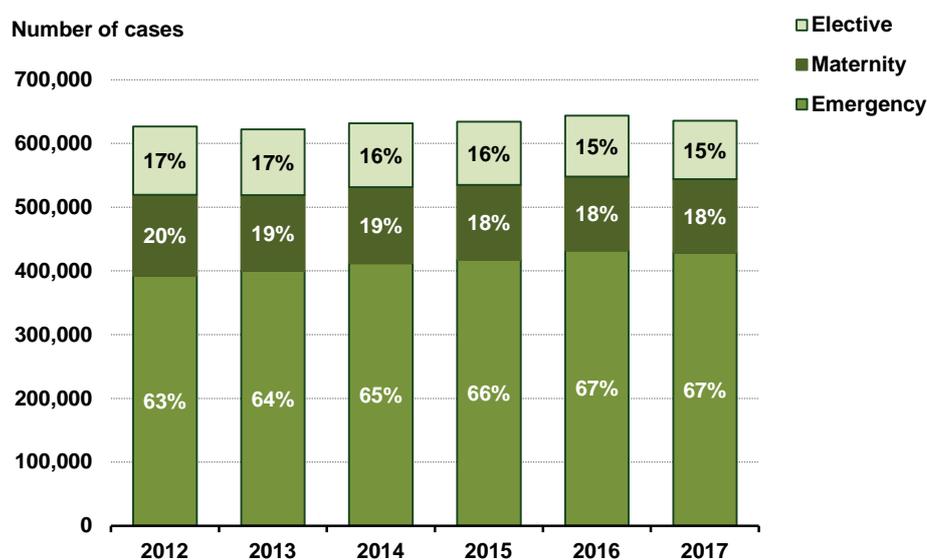
1 Consultant Contract 2008 —  
Measurement of Public : Private  
Mix.

- 16.9** When the consultants' contract was agreed, all parties to the contract agreed that HIPE would be used to measure public and private activity for inpatient and day cases. There was also an agreement that other systems were to be developed to capture consultant time on outpatient and diagnostic activity. The agreements did not make any provision for time spent in the emergency department.
- 16.10** There are no systems for capturing time spent by a medical consultant on outpatient activities. Each hospital was to make its own arrangements for measuring diagnostic activity, but information on the extent that such systems are in place and are being used to measure consultant activity is not available centrally. It is also not clear how the information available locally on diagnostic activity would be linked with HIPE data to enable conclusions be drawn on the level of a consultant's public and private activity in an acute public hospital.

### *Attributable*

- 16.11** In order for the measure of public and private activity to be a good measure of performance, the activity within an acute public hospital must be capable of being influenced by actions which can be attributed to the HSE. However, the HSE's ability to effect a change in the level of private activity within a public hospital is limited.
- 16.12** Information in HIPE for inpatients between 2012 and 2017 shows that the majority of inpatients were admitted having first attended the emergency department or were maternity cases (see Figure 16.3). In these cases, the HSE has no control over the pattern of public and private patients presenting for treatment, and in all cases, patients are treated in order of clinical priority.

**Figure 16.3 Inpatient discharges, 2012 to 2017**



Source: Hospital Inpatient Enquiry System

**16.13** Inpatients admitted on an elective basis are selected for treatment from a national waiting list in accordance with the HSE's *National Waiting List Management Protocol*. This stipulates that all patients added to the waiting list be assigned a clinical priority — 'routine' or 'urgent'. It further provides that patients be scheduled for treatment in the following order

- priority 1 — patients urgently requiring treatment where treatment has previously been cancelled
- priority 2 — patients urgently requiring treatment
- priority 3 — patients not requiring urgent treatment and proposed treatment previously cancelled
- priority 4 — patients not requiring urgent treatment selected in chronological order.

### **Verifiable**

**16.14** Any system that is used to produce performance information should be subject to validation on a regular basis. In 2015, the HSE engaged an external consultant to undertake a review of the quality of HIPE data and to assess whether the quality of the data was sufficient to support the introduction of the activity-based funding model in the acute hospital sector.<sup>1</sup>

**16.15** The review found that the quality of the current HIPE data was sufficient for activity-based funding in acute hospitals. However, the review found that hospitals in general were under representing true clinical complexity and that there was a need to reduce variation between hospitals. The review noted that improvements in the structure and quality of the medical record are critical to improve the quality of current clinical coding.

### **Hospital activity**

**16.16** Prior to 2013, private activity levels within public hospitals were controlled through bed designation — beds in public hospitals were designated as either public or private and private activity limits were based on the ratio of private beds. In most cases, this was around 20%. Bed designation was removed by the Health (Amendment) Act 2013, which in effect removed this limit.

**16.17** There are 48 acute hospitals operated or funded by the HSE. There is currently no target level of private activity set for individual hospitals. HIPE data at end 2017 shows that public treatment activity was above 80% in around 70% of hospitals for inpatients (Figure 16.4) and around 65% for day cases (Figure 16.5).

### **Comparable**

**16.18** In order for the HSE to monitor and manage trends in public and private activity levels, the measure should be comparable between current and past periods, and between hospitals. Although the HSE compares a hospital's activity level for the current period to past periods, it does not draw comparisons between individual hospitals.

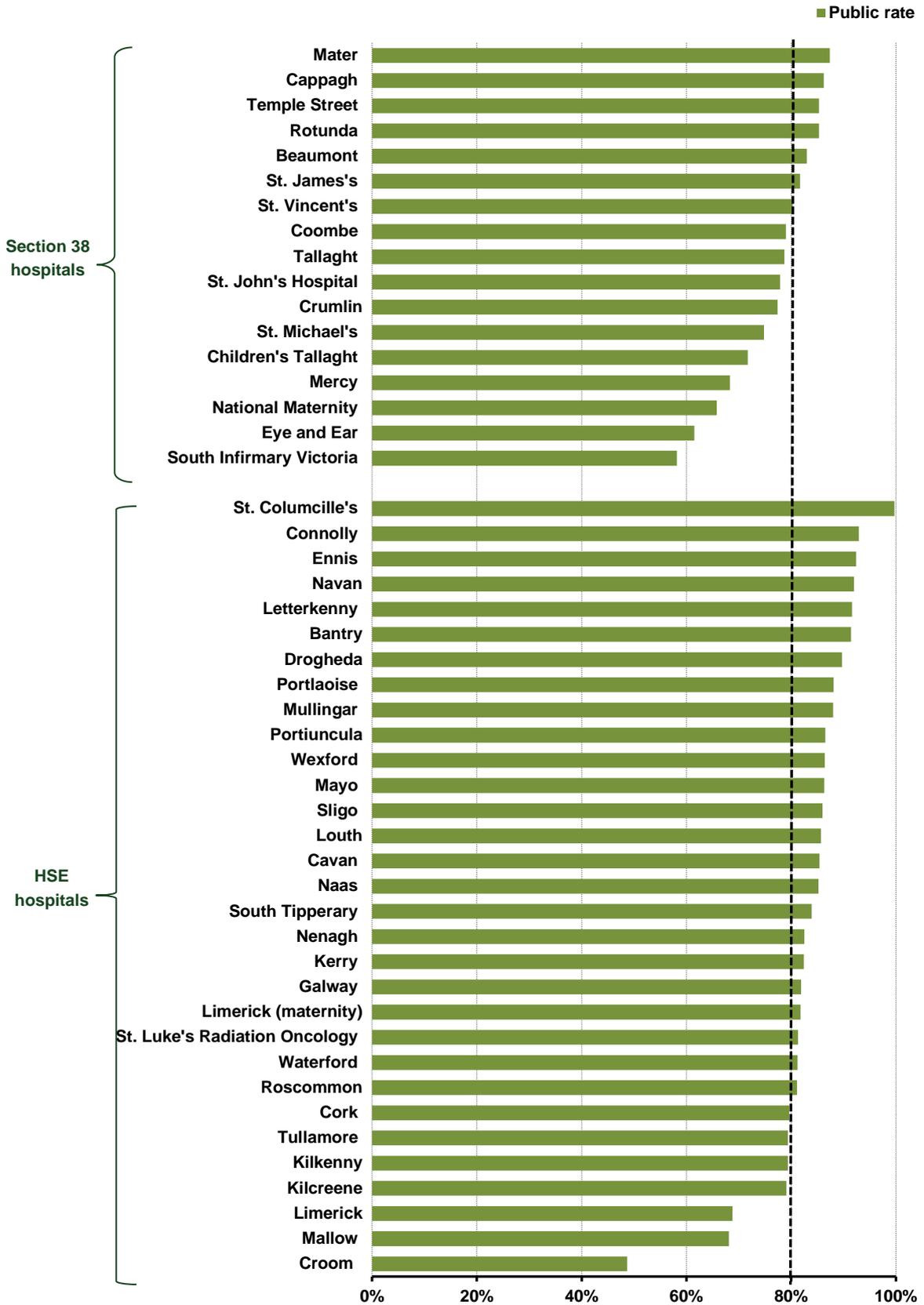
<sup>1</sup> In January 2016, the HSE introduced activity-based funding in the acute hospital sector. Under activity-based funding, grant allocations are provided to hospitals based on national agreed prices and the number and mix of patients that they treat.

**16.19** Hospitals are limited in terms of controlling the pattern of public and private activity presenting for treatment, which may inter alia reflect variable rates of private health insurance among the catchment population. Other factors outside the control of the hospital may also affect public and private activity levels including

- 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.

**16.20** Even in specialist hospital types, significant variances in the ratio of public treatment emerge. For example, the proportion of public inpatient treatment in maternity hospitals in 2017 varied from 66% in the National Maternity Hospital to 85% in the Rotunda Hospital. Similarly, Croom Orthopaedic Hospital treated 49% public patients in 2017, compared to 86% in Cappagh National Orthopaedic Hospital.

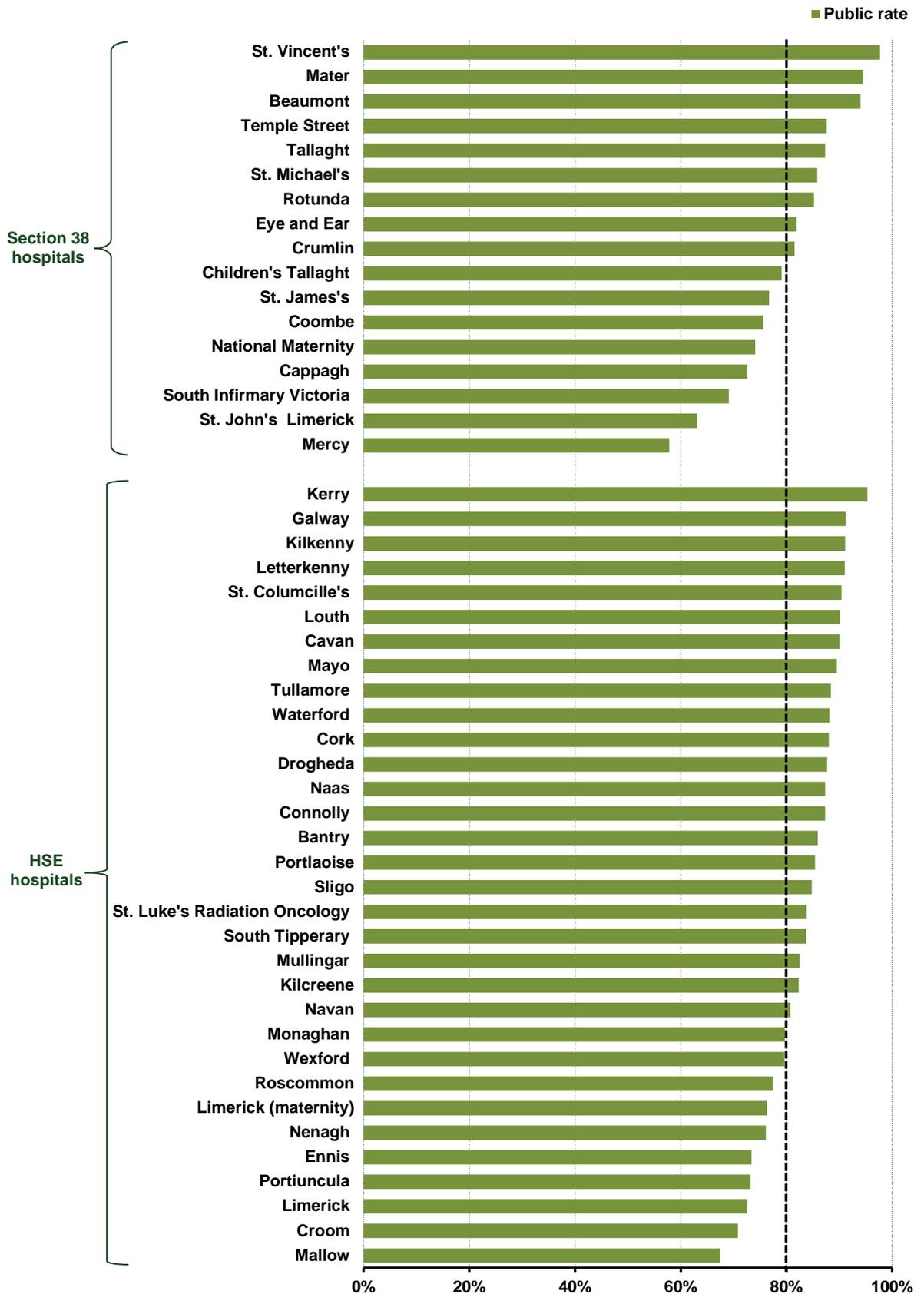
Figure 16.4 Percentage of treatment of inpatients on a public basis by acute public hospitals, in 2017



Source: Health Service Executive HIPE

Note: a Excludes Monaghan General Hospital as it is a day hospital only and does not provide inpatient service.

Figure 16.5 Percentage of treatment of day cases on a public basis by acute public hospitals, in 2017



Source: Health Service Executive — Hospital Inpatient Enquiry System

### Medical consultants' activity

**16.21** The majority of medical consultants are employed under a contract agreed in 2008 between the HSE, the Department of Health and the medical consultants' representative organisations. The contract provides that the volume of a consultant's private practice may not exceed 20% of their workload in any of their clinical activities, including inpatient, day care and outpatient.

**16.22** Medical consultants already employed under previous contract arrangements that transferred to the 2008 contract have private limits up to 30%. Consultants employed under contract terms agreed in 1991 and 1997 have private practice limits based on the bed designation system that existed in hospitals up to 2013. Figure 16.6 provides details on the various medical consultant contract types as at December 2017.

**Figure 16.6 Medical consultants' contract types at 31 December 2017**

Group	Contract type	Number	Onsite private limit	Allowable off-site private practice	
				Outpatient	Inpatient
2008 contract — new appointments	A	558	n/a	○	○
	B (b)	1,343	20%	○	○
	C	141	20%	●	●
2008 contract — existing consultants	B (a)	519	30%	●	○
	B (*)	302	30%	●	●
Other contracts	1997 (1)	200	BD <sup>a</sup>	●	○
	1997 (2)	162	BD <sup>a</sup>	●	●
	1991 (2)	2	No limit	●	●
<b>Total</b>		<b>3,227</b>			

Source: Health Service Executive

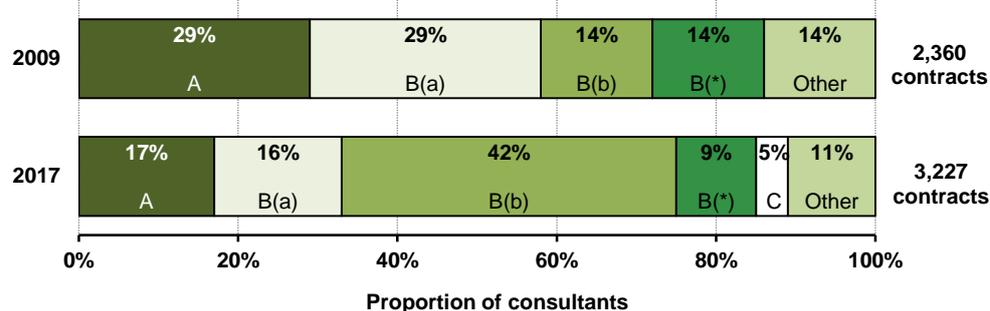
Note: a BD = bed designation. Consultants that can engage in on-site private practice subject to the requirement that a consultant's overall proportion of private patients should not exceed the ratio of designated private beds.

● Yes

○ No

**16.23** The number of consultants has increased from around 2,400 in 2009 to just over 3,200 at the end of 2017. However, the proportion of consultants holding a Type A contract has fallen by around 12% over the same period (Figure 16.7).

**16.24** The Department of Health noted that the main reason for the decrease in Type A contracts was the non-implementation of the phased salary increases, provided for in the contract to compensate for the absence of private practice rights, along with pay cuts introduced under the Financial Emergency Measures in the Public Interest (FEMPI) Act 2009. This dis-incentivised Type A posts where consultants are remunerated solely by way of salary and are not permitted to engage in private practice of any kind.

**Figure 16.7 Movement on contract types between 2009 and 2017**

Source: Health Service Executive

**16.25** While private practice limits for the majority of medical consultants range between 0% and 30%, the overall national target of 20% is consistent with the current mix of consultant contract types as demonstrated by the weighted hours shown in Figure 16.8.

**Figure 16.8 Private treatment limits based on current mix of contract types**

Contract type	Number of consultants	Number of hours per consultant <sup>a</sup>	Total number of hours	Private limit	Total number of private hours	Overall private rate
A	558	1,872	1,044,576	0%	—	
B(b)	1,343	1,872	2,514,096	20%	502,819	
C	141	1,872	263,952	20%	52,790	
B (a)	519	1,872	971,568	30%	291,470	
B (*)	302	1,872	565,344	30%	169,603	
Other	364	1,872	681,408	27.5% <sup>b</sup>	187,387	
<b>Total:</b>	<b>3,227</b>		<b>6,040,944</b>		<b>1,204,069</b>	<b>19.9%</b>

Source: Analysis by Office of the Comptroller and Auditor General

Notes: a Assume that all consultants work a 39 hour week with four weeks annual leave.

b For those consultants whose private limit is based on bed designation the limit can range between 10% and 45%. A mid point of 27.5% was assumed for the purpose of this analysis.

### **Monitoring of consultant contracts**

**16.26** 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.

**16.27** In 2017, the HSE engaged an external reviewer to examine consultant private activity levels in support of the HSE defence against a legal case brought by hospital consultants. One of the objectives of the review was to estimate the level of non-compliance with contract private practice limits across the sector.

- 16.28** The external reviewer examined a sample of public/private practice ratios for day case and inpatient care, for the years 2010 to 2016, for 413 consultants involved in the legal case. The underlying data was not readily available for review and required the completion of a return by each hospital providing a breakdown of activity for each consultant between public and private for inpatient and day cases. The external reviewer noted that there were significant gaps in the returns provided due to consultants having retired, there being no agreed activity measurement system in place, and information not being available from HIPE such as radiology reports. This limited the extent to which conclusions could be drawn.
- 16.29** The external reviewer concluded that, across the cases where data was available, around one third of consultants were not compliant with their required private limits. However, the representativeness of the findings is uncertain given the numbers of cases examined by the reviewer and the data challenges faced.

### ***Recent developments***

- 16.30** In July 2017, the Secretary General of the Department of Health wrote to the Director General of the HSE citing concerns that consultants may be exceeding their permitted level of private practice within the public hospital system and may be exceeding their off-site private practice rights or engaging in off-site private practice while being employed under a contract that does not permit any off-site private practice.
- 16.31** In April 2018, revised monitoring arrangements were agreed between the Department of Health and the HSE. The arrangements are characterised by assurance/compliance statements from individual consultants to the hospital, an annual report from the hospital to the hospital group and written assurance from the hospital group to the HSE's National Director of Acute Hospitals attesting to compliance with private practice limits. Details of the revised arrangements are set out at Annex 16A.

### **Conclusions**

- 16.32** Acute public hospitals in Ireland carry out both public and private activity. Most of the funding for public hospitals is provided by way of an Exchequer grant. The balance is met from the collection of private patient fee income. In 2017, HSE private patient income was around €305 million.
- 16.33** In order to preserve a set level of acute hospital capacity for public patients, the HSE seeks at a national level to limit private activity to 20%. Up to 2013, the ratio of public to private beds in a public hospital provided a basis for limiting private treatment activity. Since the removal of bed designation, individual hospitals currently have no set limit on private activity. The majority of individual consultants' contractual private practice levels can range between 0% and 30%.
- 16.34** In practice, the HSE, hospitals and individual consultants have limited control over the private activity levels as the majority of patients admitted to hospital are maternity admissions or admitted from the hospitals' emergency departments, which must be admitted and treated in order of clinical priority.
- 16.35** The HSE monitors activity levels within acute public hospitals using the HIPE system. However, as shown in Figure 16.9, there are significant weaknesses in the use of this measure as a key performance metric across the system.

- 16.36** Although an external review in 2015 found the quality of HIPE data sufficient for activity based funding in acute hospitals, it noted that hospitals were in general under representing true clinical complexity. The HSE does not draw comparisons on activity levels between hospitals or individual consultants in order to monitor trends in activity over time.

**Figure 16.9 Acute hospital private treatment — usefulness as a performance measure**

		National level	Hospital level	Consultant level
	<i>Private practice limit</i>	≤ 20%	None	0%-30% <sup>a</sup>
<b>Criteria</b>				
<b>Relevant</b>	Measure addresses achievement of a core performance objective	✓	✓	✓
<b>Attributable</b>	Agent has the ability to influence level of activity within a public hospital	✗	✗	✗
<b>Avoids perverse incentives</b>	Use of the measure is unlikely to lead to a perverse outcome (such as public patients not having equitable access to public hospitals)	✓	✓	✓
<b>Well-defined</b>	Measure is easily understood and consistent, and measures what is intended  Data represents all public and private clinical activity involving medical consultants	✗	✗	✗
<b>Comparable</b>	Measure should be capable of being compared e.g. to past periods or between similar agents	✓	✗	✗
<b>Timely</b>	Measure produced frequently and quickly enough to track progress and for it to be useful	✓	✓	✗
<b>Verifiable</b>	The process by which public/private activity is recorded can be validated	✓	✓	✓

Source: Office of the Comptroller and Auditor General

Note: a For those consultants whose private limit is based on bed designation, the limit can range between 10% and 45%.

## Annex 16A Department of Health and Health Service Executive Assurance Measures

Figure 16A.1 Proposed assurance measures to address consultant non compliance

Assurance measure	Detail
<i>Department of Health</i>	
<b>Bed designation circular</b>	Circular to be issued to re-affirm that, notwithstanding the legislative change within the Health Amendment Act (2013) in relation to designation, the pre-determined hospital ratios continue to have affect for those consultants that hold 1997 contracts.
<i>Health Service Executive</i>	
<b>Annual compliance statement</b>	Consultants to complete an annual statement of compliance as part of the HSE's controls assurance process. The process to be overseen by the Hospital groups and may be subject to periodic audit.
<b>Annual report</b>	Annual report from each Hospital to each Hospital Group CEO confirming that <ul style="list-style-type: none"> <li>▪ compliance with contract terms relating to private practice, including provisions for on-site and off-site private practice</li> <li>▪ reports are provided to each consultant monthly on public/private practice</li> <li>▪ there are formal arrangements with clinical directors to review individual consultant performance in terms of compliance with contracted hours and private practice limits</li> <li>▪ work plans are subject to periodic review (at least annually) and when such reviews take place there are appropriate processes in place to determine public/private mix for non-admitting consultants interventions/actions.</li> </ul>
<b>Monthly performance meetings</b>	Monthly performance meetings between hospitals and hospital groups to confirm that the following is being addressed. <ul style="list-style-type: none"> <li>▪ All hospitals continue to have working arrangements in place to allow them review individual consultant private practice.</li> <li>▪ Review hospital reports on consultant public/private practice.</li> <li>▪ Review interventions/actions taken in relation to individual's deemed non compliant.</li> <li>▪ Confirm that scheduled work plan reviews have taken place and any actions arising.</li> </ul>
<b>Written assurance</b>	Hospital Groups to provide written assurance to National Director of Acute Hospitals confirming that appropriate actions have been taken to address the areas of individual consultant non compliance in terms of hours worked, off site practice and public/private mix.
<b>Internal audit</b>	HSE internal audit to offer its views on the framework and process and, in particular, whether audit against this framework would allow compliance to be established.
<b>Target reviews</b>	Target reviews of compliance in certain hospitals to ensure that the assurance process is operating at Hospital and Hospital Group level.
<b>Audit Committee</b>	HSE Audit Committee to include consultant contract compliance in its work programme and, in particular, consider compliance as part of its review of the annual internal control assurance process.

Source: Department of Health and Health Service Executive