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Reassessing private practice in public hospitals in Ireland: An overview of OECD experiences

Michael Mueller,

Karolina Socha-Dietrich

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REASSESSING PRIVATE PRACTICE IN PUBLIC HOSPITALS IN IRELAND
An overview of OECD experiences

Michael Mueller and Karolina Socha-Dietrich*

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Authorised for publication by Stefano Scarpetta, Director, Directorate for Employment, Labour and Social Affairs

(*) OECD, Directorate for Employment, Labour and Social Affairs, Health Division

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Abstract

In 2017, the "Sláintecare Report" proposed a comprehensive overhaul of the Irish health system including a reform proposal to phase out private practice in public hospitals to end the unequal treatment of public and private patients – private patients typically have quicker access to care – and reduce waiting times for public patients. This paper summarises the arguments for and against this practice that were put forward to help inform the subsequent policy debate. The paper compares how private practice is regulated and organised in Ireland with the situation in four other OECD countries – Australia, France, Israel and the United Kingdom - and discusses the costs and benefits of private practice in public hospitals, and highlights potential consequences of a ban on this practice. It also describes the information required when making a decision whether to ban this practice or not. Finally, the paper discusses some alternative policy approaches that could replace or complement a ban of private practice to discontinue the unequal treatment of public and private patients.

Résumé

En 2017, le « rapport Sláintecare » a proposé une refonte complète du système de santé irlandais, y compris une proposition de réforme pour éliminer progressivement la pratique privée dans des hôpitaux publics afin de mettre fin au traitement inégal des patients publics et privés - les patients privés ont généralement un accès plus rapide aux soins - et réduire les temps d'attente pour les patients publics. Ce document résume les arguments pour et contre cette pratique qui ont été avancés pour éclairer le débat politique qui a suivi. Le document compare la façon dont la pratique privée est réglementée et organisée en Irlande avec la situation dans quatre autres pays de l'OCDE – l'Australie, la France, l'Israël et le Royaume-Uni. Il discute des coûts et des avantages de la pratique privée dans des hôpitaux publics, et met en évidence les conséquences potentielles d'une interdiction de cette pratique. Il décrit les informations requises pour décider d'interdire ou non cette pratique. Et il discute enfin des approches politiques alternatives qui pourraient remplacer ou compléter une interdiction de la pratique privée pour mettre fin au traitement inégal des patients publics et privés.

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Executive Summary

The treatment of private patients in public hospitals alongside public patients is common in a number of OECD countries. From a health system perspective, there are pros and cons with this practice. A main disadvantage is that it reduces access to care and the responsiveness to care for public patients. Moreover, public trust in the health system can be eroded by creating inequities in treatment between public and private patients. On the other hand, the possibility to engage in private practice can make employment for clinicians in the public system more attractive, and facilitate the hiring and the retention of health professionals. The treatment of private patients can also provide additional revenue for public hospitals when budgets are tight. Finally, it enhances the choice of patients if they can select among a bigger pool of service providers.

The interdiction of such a practice was part of a wider health reform proposal for Ireland presented in 2017 ("Sláintecare Report") leading to subsequent discussions about the possible effects and impact of such a ban. Such a move would lead to a clear separation of the treatment of private patients (only possible in private hospitals) from that of public patients (only possible in public hospitals with some exceptions) but the net effects of banning private practice are unclear.

While it is obvious that such a measure would eliminate the unequal treatment of public and private patients in public hospitals, it is unclear whether waiting times for public patients can be effectively reduced or the gap in access between patients in public and private hospitals narrowed by such a reform; the final effects will depend on implementation design and on the presence of other conditions that go beyond this specific policy intervention (the ban). There are many repercussions such a move can have on the health system, such as changes in the employment opportunities of doctors, the hospital landscape and the private health insurance market. Key information required when making the decision whether a ban should be pursued include an understanding as to how doctors working in the public system can be retained, assessing the probability that they seek employment in the private sector or abroad, and evaluating the capacity of private hospitals to treat patients that want to be treated as private patients. Extensive stakeholder consultations could help mitigate possible adverse outcomes of a ban.

Some peculiarities of the Irish health system help explain why such a ban is under consideration but also show the challenges that the implementation of such a ban may entail. Ireland has a low bed capacity and the highest bed occupancy rate among OECD countries which translates into long waiting times for hospital treatment for public patients. Voluntary health insurance that covers private practice in private or public hospitals for faster access to services is widespread among the population and finances an important share of hospital activity. On a per capita basis there are fewer doctors in Ireland than across the OECD and the vast majority of all senior physicians ("consultants") are allowed to engage in private practice to complement their public salary.

While private (or dual)[1] practice in public hospitals exists in many other countries it is not necessarily perceived as a major policy concern: the context in which these arrangements

[1] While private practice refers to the situation when a doctor in a public hospital can see private patients in the same hospital, dual practice more generally refers to a situation where a hospital doctor is permitted to treat public and private patients in the same or different settings.

operate matters. Experience from Ireland, Australia, France, Israel and the United Kingdom show that regulation and the organisation of private (and dual) practice can be very complex and comes with country-specific challenges - the governance of physicians' contracts being one of them.

To address the issues of long waiting times and unequal treatment in public hospitals, Ireland could also consider a set of alternative or complementary options to the ban on private practice. These could include an expansion of hospital capacity available for public care provision by changing the purchasing arrangements to allow the public purchaser to also contract private hospitals, or the improvement in waiting time management by introducing a waiting time guarantee for public patients.

1. Introduction

1. Despite better than average progress in improving life expectancy and displaying some other good health outcomes (Ireland has the highest proportion of people who report to be in good health in Europe), the Irish health system faces certain challenges which may adversely affect health system performance (OECD/European Observatory on Health Systems and Policies, 2019). While health spending per capita in Ireland is above the OECD average, performance is below average for some indicators on quality of health care, as measured by high rates of hospital admissions for chronic conditions such as COPD or comparably low 5-year survival rates for breast or colon cancer. Moreover, Ireland is among the few OECD and EU countries where health care coverage is not yet universal, with only around 50% of the population having access to publicly funded primary care. Effective and timely access to health services is also an issue in Ireland, with high waiting times for outpatient specialist consultations and elective surgery by international standards.

2. These shortcomings are generally acknowledged in Ireland. In 2016, an all-party "Parliamentary Committee on the Future of Healthcare" was set up to develop long-term policy directions for the Irish health system. In May 2017, the Committee published a set of detailed reform proposals – the "Sláintecare Report"– with the overarching goal to move towards a single-tier, person-centred health system with universal coverage (Oireachtas, 2017). It proposes a fundamental overhaul of the Irish health system within a decade touching on all health system domains, including changes to entitlements, care models and service delivery, financing mechanisms and organisation.

3. One of the recommendations included in the Sláintecare Report refers to the phasing-out of private practice in public hospitals[2]. More precisely, Key Recommendation 10 proposes to:

- "Disentangle public and private health care financing in acute hospitals and remove ability of private insurance to fund private care in public hospitals".

4. This recommendation should not be seen in isolation but as part of wider initiatives to expand public hospital activity and to provide timely access to public hospital care. To support the expansion of public hospital activity, a general increase in capacity is also suggested in the Sláintecare Report. The report also proposes some other measures to provide timely access to public hospital care including a waiting times guarantee, the re-orientation of care towards primary care settings, and addressing understaffing.

5. The Sláintecare Report recommends the removal of private practice in public hospitals within five years, and a complete replacement of the income generated by public hospitals with private practice through public funding (estimated at EUR 649m in 2016 and EUR 621m in 2017). Private insurance coverage for outpatient care and elective surgery would continue to exist but could only be delivered in private hospitals.

[2] In public hospitals in Ireland patients can choose to be either treated as public or private patients. Private patients have to bear the cost of accommodation and consultancy fees – payable to the physicians – themselves or have voluntary private insurance to cover those costs. A more comprehensive discussion of the terms private/dual practice follows in chapter 3. An in-depth description of the Irish situation is presented as a case study in the Annex.

6. Due to the complex nature and the many repercussions the removal of private practice can have in different parts of the health system, the Sláintecare Report recommends conducting an independent impact analysis of the separation of private practice with the particular aim to assess adverse and unintended consequences.

7. Against this background the Irish Department of Health requested the OECD Secretariat in 2018 to provide information on countries' experience and empirical evidence on the phasing out of private practice in public hospitals and international experience related to the intertwining of private healthcare in public hospital systems[3]. This document synthesizes this information and could serve as an input for countries that are considering a change in the regulation regarding private practice in public hospitals.

8. This paper is structured as follows: Chapter 2 provides an overview of how Ireland compares internationally on a number of health indicators that are important in the context of the proposed ban. It specifically compares the hospital landscape, the role and size of private health insurance and the employment situation of doctors across OECD countries. After developing a typology of different types of private/dual practice, Chapter 3 compares the organisation and regulation of private practice in public hospitals in Ireland to the situation in four other OECD countries –Australia, France, Israel and the United Kingdom. The country-specific circumstances underlying this comparison are described in detail in five case studies in the annex of this report. Chapter 4 discusses conceptually the benefits, costs and implementation challenges of private practice in public hospitals. This chapter highlights some key information that is required when making a decision to ban private practice or not and also highlights some of the alternative or complementary reform options that could be considered to remove the unequal treatment of public and private patients and reduce waiting times.

[3] The paper refers to the situation in countries as of 2018. Since then, discussions may have evolved. For example, in December 2019 the Irish government decided that new consultancy contracts will be offered in summer 2020 to all specialists in public hospitals no longer allowing private (and dual) practice. In exchange, public salaries will be considerably increased. Consultants with existing private practice contracts may continue to exercise this right if they do not want to opt for the new contract.

2. Hospital landscape, private insurance, and physician employment: How does Ireland compare to OECD countries?

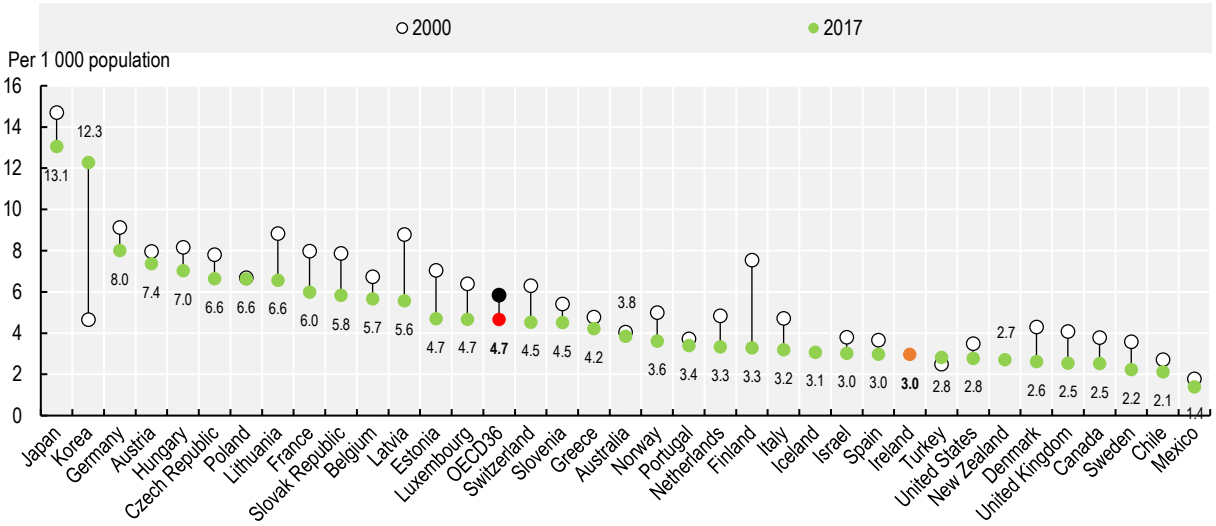
9. This chapter looks at a number of key features of the Irish health system that are important to understand in the context of the debate on a possible ban of private practice in public hospitals and compares the situation in Ireland to that in other OECD countries. The chapter describes in particular the hospital landscape, the role of private health insurance and the employment situation of doctors. The comparison shows that Ireland has the highest bed occupancy rate across all OECD countries as a result of below average hospital capacity but average levels of hospital activity. Private health insurance plays a relatively large role in Ireland and is an important financing source for hospitals. Ireland has a below-average number of physicians and is relying to a relatively large extent on foreign-trained doctors. Finally, available data on waiting times for elective surgery suggests that patients in Ireland have to wait longer for treatment than in other OECD countries.

2.1. Hospital landscape

Overall bed capacity in Ireland is below the OECD average

10. In terms of overall capacity, Ireland has fewer available hospital beds than most OECD countries (Figure 1). With 3.0 beds per 1,000 population, Ireland has around 40% less capacity than across the OECD on average (4.7), but more than the United Kingdom (2.5) and Scandinavian countries such as Denmark (2.6) or Sweden (2.2). In most OECD countries, bed density has fallen in recent years, by more than 15% on average between 2000 and 2017, as a consequence of efforts made to move treatment out of the inpatient sector.

Figure 1. Hospital beds per 1 000 population, 2000 and 2017 (or nearest year)



Note: Day care beds are excluded
Source: OECD Health Statistics 2019.

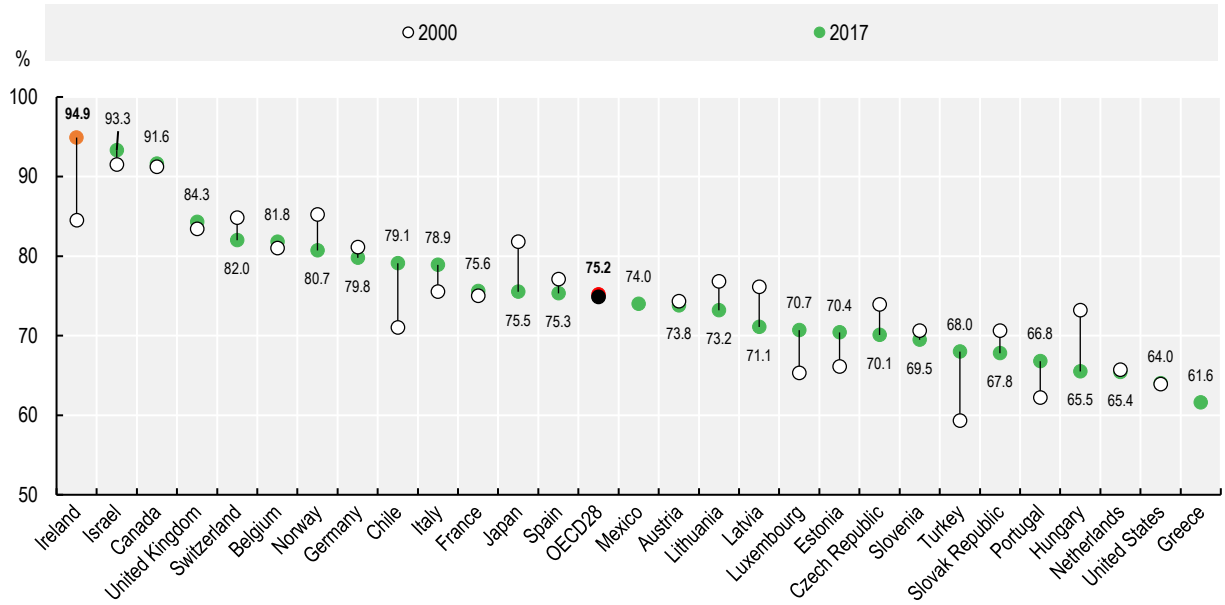
High bed occupancy rate is a major issue in Ireland

11. Ireland is around the OECD average in terms of overall *hospital activity*. In 2017, the number of hospital discharges per 1,000 population stood at 136, slightly below the OECD average of 154 and comparable to countries such as the United Kingdom (131) and New Zealand (141).

12. With an average length of stay (ALOS) of 6.1 days, Ireland is below the OECD average (7.7) and the United Kingdom (6.9), but above Sweden (5.7) and Australia (5.6). In many countries, this figure has decreased over the last decade or so, reflecting changes in health care delivery and efficiency gains in care provision. This is also true in Ireland.

13. As a consequence of lower capacity, but similar activity levels compared with other OECD countries, Irish hospitals are working at near full capacity year-round: nearly 95% of all acute care beds are occupied on an average day. Together with Israel, Ireland records the highest occupancy rate across all OECD countries – far above the OECD average of 75% - with little excess capacity for emergency situations (Figure 2). While this rate has not changed much in most countries, it increased by around 10 percentage points in the last decade in Ireland. In a number of OECD countries, an occupancy rate of 85% is broadly considered to be the limit for safe occupancy for patients (OECD, 2012a).

Figure 2. Occupancy rate of curative (acute) care, 2000 and 2017 (or nearest year)



Source: OECD Health Statistics 2019.

Public and private hospitals both play a role in the provision of hospital services in Ireland

14. The involvement of the private sector in the delivery of inpatient hospital services in Ireland appears to be roughly comparable to other OECD countries. In 2017, around one in five of all acute care, mental health and specialty hospitals in Ireland were private for-profit. This share is slightly below the OECD average, which stands at 30% (OECD Health

Statistics 2019). When it comes to hospitals beds, national data in Ireland suggest that around 15% of acute care beds are in private for-profit hospitals (Department of Health, 2018a), very close to other OECD countries. On average across the OECD, 69% of all hospital beds[4] are in public hospitals, 18% in private not-for-profit hospitals and 13% in private for-profit hospitals, but with a high degree of variation across countries. While all or nearly all hospital beds are in public hospitals in Iceland and Slovenia, this share is less than 50% in Germany, the United States, Korea and the Netherlands.

2.2. Financing of hospital services

Activity-based funding has been introduced in Ireland to finance hospital activity

15. Across the OECD, the main mechanisms for the key purchaser – predominantly public payers – to finance hospital activity are global budgets or case-based payment systems, such as through the use of Diagnosis-related groups (DRG). Other methods such as line-item budgets or fee-for-service (FFS) are less frequently used. However, payment systems are typically mixed which means that different activities in hospitals are remunerated differently (OECD, 2016). Moreover, not all hospitals are necessarily financed the same way: importantly, there may be differences in how public hospitals are reimbursed compared to private hospitals.

16. Since 2016, inpatient and day case activity financed by the Health Service Executive (HSE) have been paid for on a case base called 'activity-based funding (ABF)'[5] in public hospitals in Ireland; all other activity (emergency departments, outpatient) are financed via block grants. Private hospitals can set their own prices based on agreements reached between hospital and private insurers.

Hospitals in Ireland rely much more on private health insurance financing than elsewhere

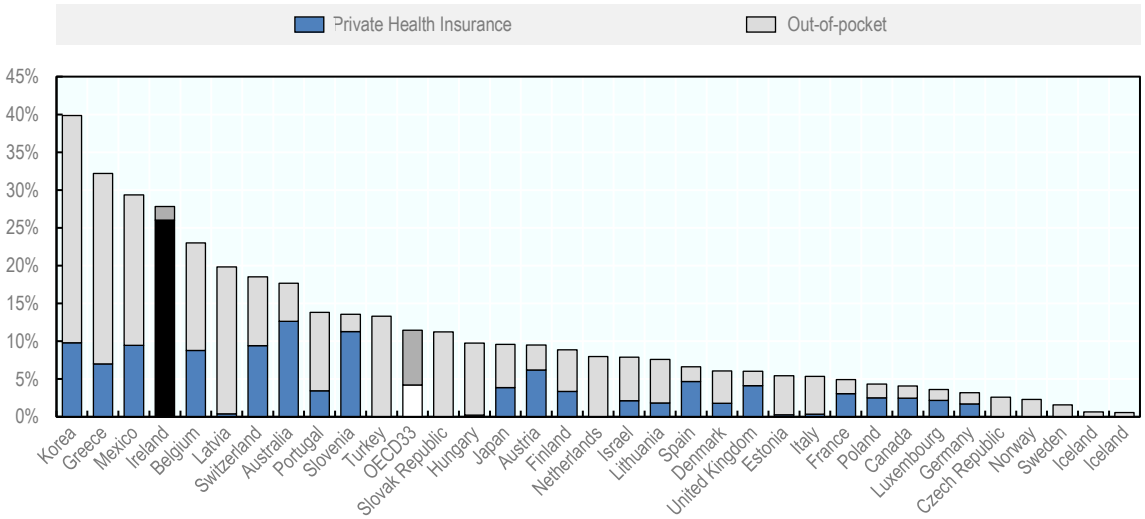
17. Looking at the composition of who is paying for hospital services (including inpatient, outpatient and day cases) across all hospitals regardless of ownership, it is interesting to note that the share of private health insurance stands at more than 25% in Ireland – much higher than in any other country (Figure 3)[6]. On average, this share stands at 4% across the OECD, and accounts for 13% in Australia, 4% in the United Kingdom, 2% in Canada and is either negligible or does not exist in Scandinavian countries. On the other hand, the share financed out-of-pocket by patients in Ireland is slightly lower (2%) since those using their PHI policy to be treated as private patients typically do not need to make additional co-payments. Yet, out-of-pocket payments play a large role in hospital financing in some countries, such as in Greece and Korea (around 25-30%).

[4] Including acute care, mental health and rehabilitative hospitals

[5] ABF is based on the Australian DRG system 'AR-DRG'

[6] Private health insurance refers in this context to *voluntary* private insurance schemes excluding compulsory private schemes that exist in some countries such as Chile or Germany.

Figure 3. Share of all spending in hospitals financed by private health insurance and out-of-pocket, 2017 (or nearest year)

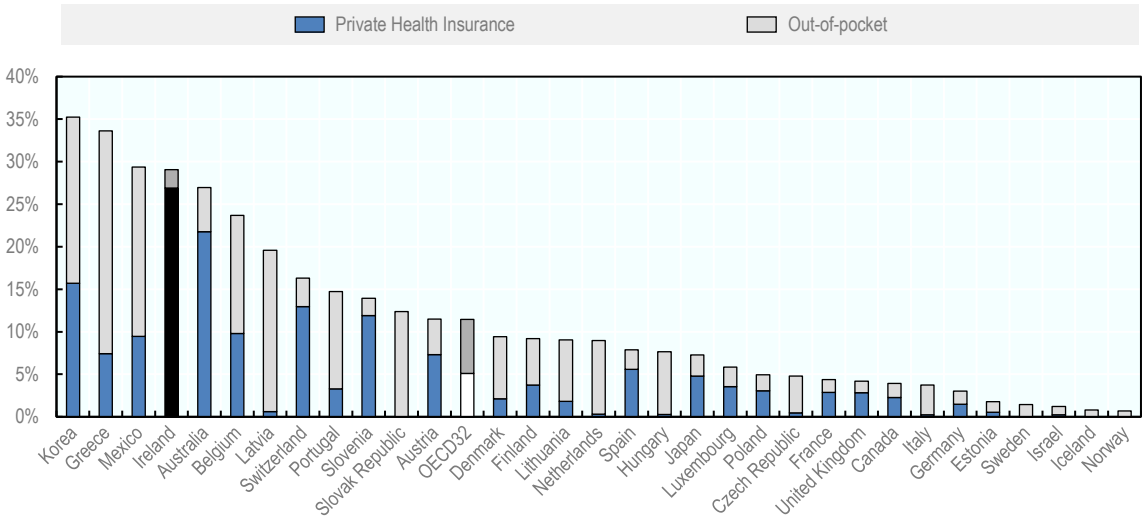


Note: Private health insurance refers to voluntary insurance. Data for the United States not available.
Source: OECD Health Statistics 2019.

18. The same pattern is observable if instead of the composition of all hospital financing the composition of the financing of inpatient services[7] is analysed (Figure 4). In this analysis, Ireland has roughly the same share as for hospitals: this suggests that there is little difference in the way inpatient and outpatient activity in hospitals is financed. This is not necessarily the case in all countries: in Australia, for example, the share of private sources financing inpatient activity is substantially higher than the share financing all hospital activity – hinting at differences in the way inpatient and outpatient hospital services are financed and the extent to which hospitals are multi-functional.

[7] This refers to inpatient curative-rehabilitative care which is typically provided in hospitals but could also be provided occasionally by some ambulatory care providers depending on the organisation of health care in a country.

Figure 4. Share of all spending for inpatient care financed by private health insurance and out-of-pocket, 2017 (or nearest year)



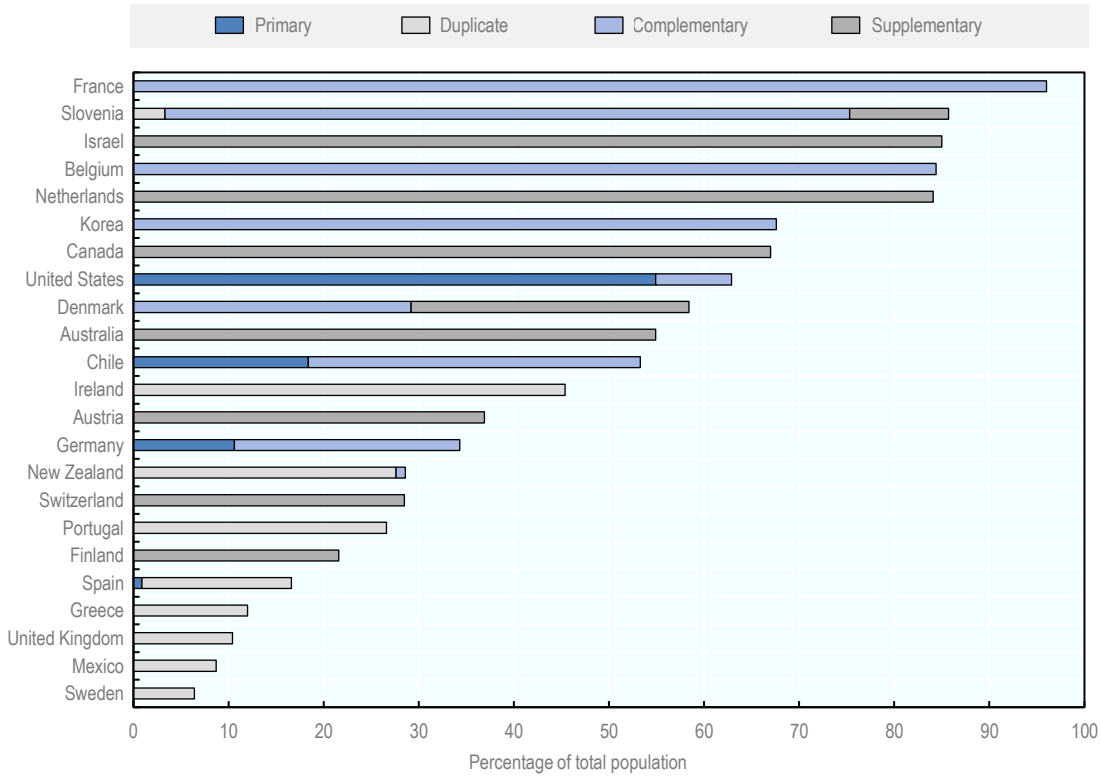
Note: Private health insurance refers to voluntary insurance. Data for the United States not available.
Source: OECD Health Statics 2019.

2.3. The role of private health insurance

Nearly half of the population in Ireland has private health insurance to cover costs for "private" treatment

19. Private health insurance plays an important role in some OECD countries where it covers the costs of health services and goods not covered (or only partially covered) by public schemes. It can perform different functions in different countries and Figure 5 highlights the large differences in the take-up and role of private insurance across countries. Generally, private insurance can *complement* public coverage (by covering any cost-sharing left after basic coverage), *supplement* public coverage (by covering services not included in the public benefit basket), *duplicate* public coverage (providing faster access to services or a larger choice of providers), and it can provide *primary coverage* if public coverage is not available for some population groups. In Ireland, private health insurance plays a predominantly "duplicate" role, providing faster access to care for around 45% of the population in 2017. The function of private health insurance in Ireland has some similarities with Australia (where PHI can be both duplicate and supplementary), New Zealand, Portugal, Spain, Greece, and the United Kingdom.

Figure 5. Private health insurance coverage, by type, 2017 (or nearest year)



Note: Private health insurance can be both duplicate and supplementary in Australia; complementary and supplementary in Denmark and Korea; and duplicate, complementary and supplementary in Israel and Slovenia. In countries where primary health insurance coverages exists, it is typically compulsory.
Source: OECD Health Statistics 2019.

20. From a financing perspective, the share of private health insurance in total health spending is around 13% in Ireland, roughly triple the OECD average and around the values seen in Australia (10%), Israel (11%), Canada (13%) and Slovenia (14%). When analysing the spending structure of private health insurance, Ireland stands out as being focused on inpatient and day case activity which account for around ¾ of all health spending by PHI in the country. In terms of structure there are again similarities with Australia and Greece, but also the United Kingdom (due to the comparably high share of day case activity).

2.4. Waiting times for hospital treatment

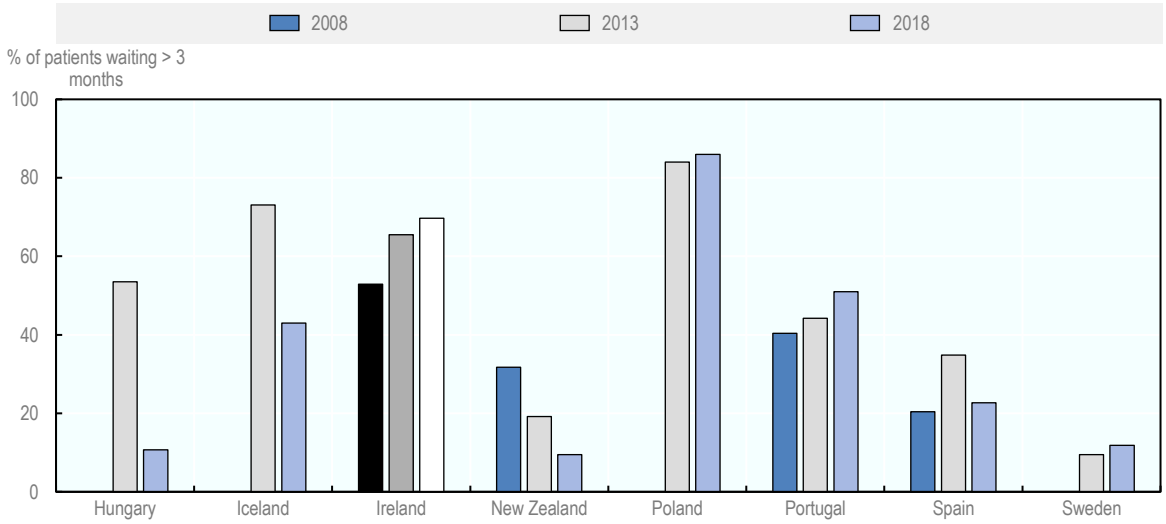
Waiting times for elective surgery appear to be relatively long in Ireland

21. Although comparable measures for waiting times are generally difficult to establish, the existing data for a number of elective surgeries suggest that waiting times in Ireland are long (Figure 6). For example, nearly 70% of Irish patients on the waiting list for cataract treatment wait more than three months for surgery. This share is much lower in New Zealand (10%), Sweden (12%) and Spain (23%) - other countries with predominantly tax-financed health systems. Moreover, this share has been gradually increasing in recent years in Ireland (before decreasing again in 2018) while some countries were more successful in bringing it down. The situation is similar for other interventions such as coronary bypass and knee replacement where a substantially higher share of

Unclassified

patients in Ireland have to wait three months or more for surgery compared to those in New Zealand, Sweden or Spain.

Figure 6. Waiting times for cataract surgery, percentage of patients on waiting list who wait for more than 3 months, 2018 or latest year, selected OECD countries



Note: International data availability is limited for waiting times indicators.
Source: OECD Health Statistics 2019.

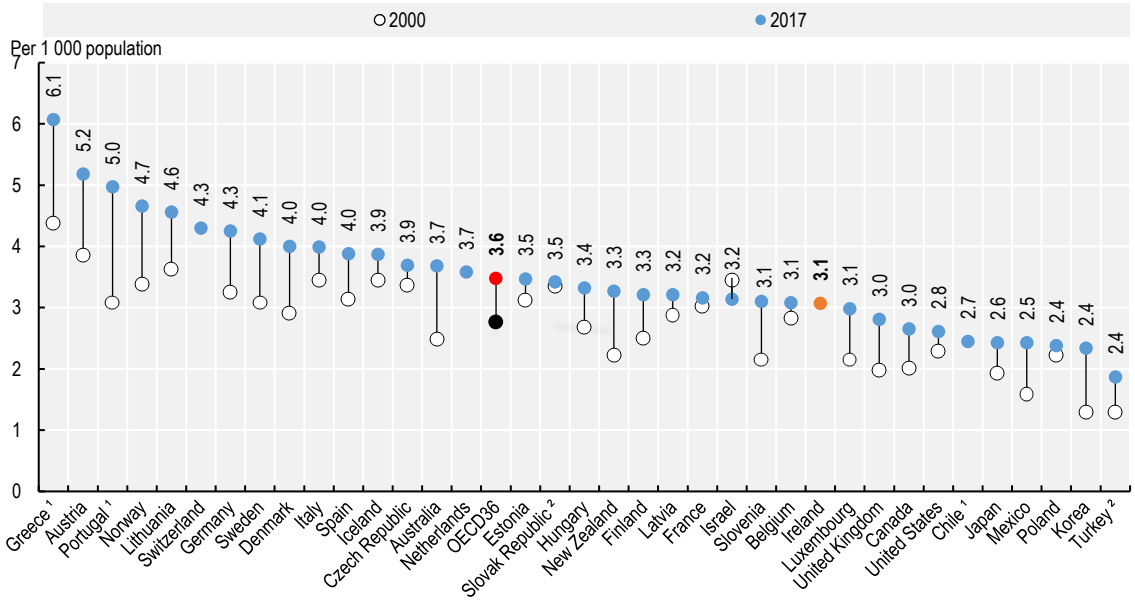
2.5. The number and composition of doctors

Ireland has comparably few doctors and relies a lot on foreign-trained doctors

22. There are fewer practicing doctors in Ireland (3.1 per 1,000 population) than the OECD average (3.6), with about 2/3 of doctors in Ireland being employed in public hospitals (Figure 7). Looking at the age structure of physicians, doctors in Ireland tend to be younger than in most OECD countries – the share of doctors aged 55 and over only stood at 22% in 2017 compared to 34% across the OECD. A relatively high number of medical graduates in more recent years may explain part of this: In 2017, the number of medical graduates relative to the size of the population in Ireland was higher than in any other OECD country (24.9 per 100,000 population) and around double the average across the OECD.

23. The mobility of medical graduates and doctors appears to be high in Ireland– both when looking at the outflow of Irish-trained doctors and the inflow of foreign-trained doctors into Ireland. Behind Israel and New Zealand, the share of foreign-trained doctors in Ireland is the third highest across the OECD (Figure 8). Due to data limitations, the picture of Irish-trained doctors migrating to other countries is less complete. Based on the data available, unsurprisingly, other English-speaking countries such as United Kingdom, Canada and Australia are the top destination countries for doctors trained in Ireland. For these countries – as well as for New Zealand and the United States– the annual 'migration balance' has been negative for a while, meaning that there are more Irish-trained doctors leaving for those countries than foreign-trained doctors from those countries coming to Ireland.

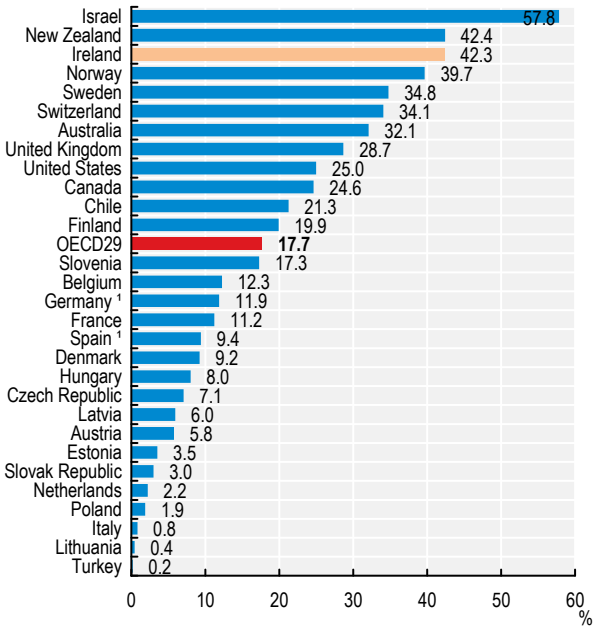
Figure 7. Practicing doctors per 1 000 population, 2000 and 2017 (ore nearest year)



Note: Ireland is one of the few countries where it is not possible to fully assess the changes in the number of practicing physicians due to data limitations.1. Data refer to all doctors licensed to practice, resulting in a large over-estimation of the number of practising doctors (e.g. of around 30% in Portugal). 2. Data include not only doctors providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of doctors).

Source: OECD Health Statistics 2019.

Figure 8. Share of foreign-trained doctors, 2017 (or nearest year)



Note: In Germany and some regions of Spain data refers to foreign-born instead of foreign-trained doctors.
Source: OECD Health Statistics 2019.

Unclassified

24. As in most other countries, doctors working in an inpatient setting are predominantly publically employed in Ireland. Only in Belgium, Canada, Luxembourg, the Netherlands and the United States are they predominantly self-employed. However, since many of them are allowed to engage in dual practice in Ireland, the income of many hospital specialists is "mixed" whereby they receive a salary for their treatment of public patients and are paid on a fee-basis for private patients. This can also be the case in other countries where dual practice is allowed.

25. For inpatient specialists, dual practice is allowed in nearly all countries but in many cases with restrictions (Table 1)[8]. In some countries dual practice may only be allowed for a certain category of doctors (e.g. the most senior ones). Depending on the country, dual practice can mean different things. This will be discussed in more detail in Chapter 3 of this report.

Table 1. Dual practice of inpatient specialists

	Is dual practice allowed for specialists supplying inpatient services?		
	Yes, always	Yes, in some circumstances only	No
AUS	X		
AUT	X		
BEL		X	
CAN			X
CHL	X		
CZE	X		
DNK	X		
FRA		X	
GRC		X	
ISL	X		
ISR	X		
JPN		X	
LVA	X		
NLD	X		
POL	X		
PRT		X	
SVN		X	
ESP	X		
SWE		X	
CHE	X		
GBR	X		

Note: Country responses may be influenced by different national notions of the term "dual practice".

Source: OECD Health System Characteristics Survey 2016; Question 31d http://www.oecd.org/els/health-systems/characteristics.htm

26. When it comes to the remuneration for salaried specialists (including both those who work in hospitals and those working outside hospitals), the remuneration level on average seems to be relatively high in Ireland[9] (USD 208,000 in 2017, adjusted for purchasing power parity) –higher than in Germany (USD 183,000) or the United Kingdom (USD 167,000). That said, international comparability of income figures is notoriously difficult to establish since there may be underreporting of certain income elements and

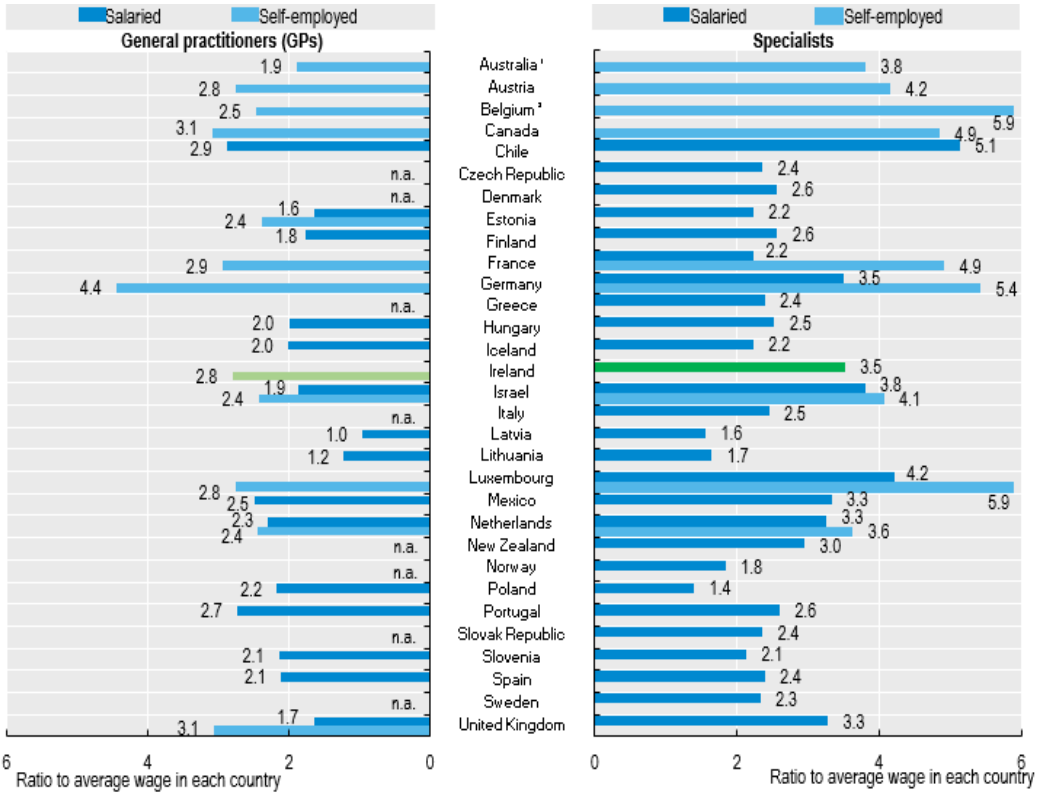
[8] The results displayed in Table 1 may partially be influenced by different national notions of the term "dual practice".

[9] This figure is underestimated as it excludes the additional income from private practice consultants are allowed to generate and income relating to emergency call-out and on-call payments except for the minimum flat annual.

possible differences in working hours. The reported salary for specialists in Ireland is 3.5 times higher than the average national wage – this gap is also more pronounced in Ireland than in many other countries, but roughly equal to the relative income of salaried specialists in the United Kingdom (Figure 9).

27. Behind the average figure, there are substantial differences in incomes between different specialties, as well as between young doctors and senior consultants. In the OECD data collection, specialists include a wide range of categories of doctors, such as paediatricians, gynaecologists and obstetricians, psychiatrists and different surgical specialities, with the remuneration level of doctors in these different specialties varying widely[10].

Figure 9. Remuneration of doctors, ratio to average wage, 2017 (or nearest year)



Note: 1. Physicians in training included (resulting in an underestimation). 2. Practice expenses included (resulting in an overestimation)
Source: OECD Health Statistics 2019.

[10] According to the definition used "specialists" refers to Specialist Medical Practitioners, defined as doctors who "diagnose, treat and prevent illness, disease, injury, and other physical and mental impairments in humans, using specialised testing, diagnostic, medical, surgical, physical and psychiatric techniques, through application of the principles and procedures of modern medicine… They specialise in certain disease categories, types of patient or methods of treatment and may conduct medical education and research in their chosen areas of specialisation."

3. Private practice in public hospitals: An overview of the situation in five OECD countries

28. This chapter aims to clarify the different types of dual/private practice and compares and contrasts the situation of private practice in Ireland with that in four other OECD countries. This comparison shows that the regulation and organisation of private practice and the challenges it may entail are very country-specific.

3.1. A typology of private/dual practice

29. Table 1 in Chapter 2 clearly highlights that dual practice is widespread across OECD countries. Yet, for a more informed discussion the terminology of private/dual practice needs to be clarified. McPake et al. (2016) developed a typology to distinguish between the different arrangements that allow health professionals to treat both public and private patients (called "dual practice"). The following four cases of dual practice can be distinguished:

i. Outside: private patients are treated in a completely separate facility such as private hospitals;

ii. Besides: private patients are treated in a private ward or clinic physically associated with a public facility but run as a private business;

iii. Within: private patients are treated inside a public facility but outside of public service operating hours or space;

iv. Integrated: private patients are treated alongside public patients but charged additional fees alongside standard ones, with the understanding of faster access and/or superior non-clinical amenities (e.g. staying in a private room).

30. The authors conclude that academics and policy makers typically restrict the term "dual practice" to type (i) and most literature refers to the pros and cons and the consequence of a *complete ban of dual practice*. Here, the literature does not appear to reach a clear consensus on the net effect of dual practice (Garcia-Prado and Gonzalez, 2007), rather the balance in the trade-off between the cost and benefits of dual practice would depend on the quality of contracting in countries (Eggleston and Bir, 2006). However, a complete ban of dual practice is not up for debate in Ireland at the moment, and so this option will not be discussed further.

3.2. Comparing private practice across 5 countries

31. In OECD countries where dual practice is permitted, this is typically restricted to the "outside" option, as in Spain and Portugal for example[11]. Ireland is in a different situation, and similar to Australia, France, Israel and the United Kingdom, in that dual practice beyond the "outside" option is allowed. Yet, each country is unique in how this is organised and regulated and Table 2 provides an overview of some key characteristics of dual practice in those countries and compares them to the situation in Ireland[12]. Briefly summarising the situations in countries, it

[11] Garcia-Prado and Gonzalez (2007) provide an overview how dual practice is regulated in a number of high and middle income countries.

[12] A much more detailed description of the organisation and regulation of dual/private practice in each of the five countries considered in this analysis is included in the Annex.

appears that Australia is most similar to Ireland, as patients with private insurance can choose to be treated in public hospitals - either as public or private patients - or in private hospitals, and doctors can see private patients in the same or different facilities. In the UK, private activity in NHS hospitals is possible but currently still on a comparatively low level. Publicly employed doctors engaging in private practice are most likely to see patients in private settings. In France, relatively few doctors employed in public hospitals are permitted to see private patients in the same setting. The situation in Israel is more complex given the fact that in addition to coverage from National Health Insurance many residents have two additional types of private duplicate insurance which allows them to be treated either as public or private patients. In that country, 'outside' dual practice in different settings is widespread and many doctors in public hospitals also see patients in private facilities (or do additional after-hours work in public hospitals for patients under the NHI package).

32. Within public hospitals, dual practice is allowed in Australia, France, Ireland and the United Kingdom but countries differ with regards to the types of services that public hospitals can provide for private patients. This can refer to treatment that is also included in the public benefit package or to services outside of the benefit package, such as aesthetic surgery. In all countries where dual practice is permitted in public hospitals, the treatment of private patients includes activities that are also covered in the public benefit package. Hence, patients could have received the same treatment in public hospitals without being treated as 'private patients' (but, possibly without the choice of doctor and less additional amenities). The situation in Israel is slightly different. Here, dual practice does not occur within public hospitals. Government hospitals and "Clalit" hospitals (these two hospital types are considered public) generally only provide services under the NHI. The simultaneous treatment of public and private patients within a single facility exists in a number of private and not-for-profit hospitals where patients can either use their national health insurance coverage or two different types of private health insurance coverage to access treatment. Regardless of differences in the implementation of the "besides" and "within" options of dual practice, the "outside" option exists for doctors in all five countries.

33. Payments for the treatment of private patients in public hospitals differ across countries. In Ireland and the United Kingdom, persons being treated as private patients pay all costs themselves or have private health insurance to cover it. In Australia and France, the costs of private treatment are at least partially met by public payers: Medicare in Australia covers 75% of the MBS fee[13] for patients who choose to be private patients while Social Health Insurance covers part of the fees and accommodation in the case of France.

[13] The Medicare Benefits Schedule (MBS) is a listing of the Medicare services subsidies by the Australian government. The MBS also defines the fee for each service considered appropriate and Medicare will cover up to 100% of the fee depending on the nature of the service.

Table 2. Key characteristics of dual practice in 5 countries

	Ireland	Australia	France	Israel	United Kingdom
Are (some) activities of private practice carried out in public hospitals also included in the public benefit package?	Yes	Yes	Yes	Private practice (financed by VHI) only in non-profit and private hospitals duplicating public coverage	Yes
Are services provided in private practice in public hospitals partially paid by public scheme?	No	Yes	Yes	Not applicable in public hospitals; private practice in non-profit and private hospitals not covered by public NHI scheme	No
Share of all doctors employed in public hospitals that engage in private practice in the same or other hospitals	~ 30% (>90% of all consultants)	~ 50% of all employed specialists	~ 5%	?	~ 45%
For those doctors that engage in private practice: what share of public income does private practice income represent?	?	?	~60%	29% of total salary for experienced doctors in government hospitals	26% of NHS income for full-time consultants (2003/04)
How much activity/revenue does private practice represent in public hospitals?	~10% of public hospital revenues (excluding consultant fees)	13.9% of separations in public hospitals are funded by PHI	negligible (physicians pay back a share of the fee to hospitals, for the Paris public hospital group the amount corresponded to 0.1% of the budget)	No private practice in public hospitals; private practice income for those hospitals that provide both NHI and VHI services presumably non-negligible	< 1% of NHS hospital revenue

Source: Authors' own assessment based on variety of different sources (most can be found in the Annex).

34. There is some variation in the share of publicly employed doctors that are allowed to see private patients - either in public hospitals or on private premises. It is very common in Ireland, Australia and the United Kingdom but some limitations nevertheless exist: in Ireland, private practice is only permitted for more senior doctors ("consultants") and similar restrictions also exist in other countries. The number of salaried doctors with the right to bill patients independently is much more limited in France where only around 5% of all doctors in public hospitals are allowed to do this.

35. Very little data is available to estimate the overall income of doctors from private practice, in particular in Ireland and Australia. In France, independent billing is estimated to represent around 60% in addition to the public salary for those doctors that engage in private practice, thus an important share of the total income. Private patient income is estimated to be less in Israel and the United Kingdom but can still be a significant income component.

36. For public hospitals, income from private patients is negligible in France and comparably small in the United Kingdom. In Ireland, income from private patients is substantial for public hospitals (10%). Although data for Australia on hospital revenues is missing it can be assumed to be important – based on the high (and growing) share of persons being treated as private patients in public hospitals.

37. The nature of dual/private practice in Ireland, Australia, France, Israel and the United Kingdom are presented in more detail in the Annex of this report along with complementary

contextual information to better understand how dual/private practice is regulated and organised, and the current national debates surrounding the practice.

38. In each country current discussions focus on different issues:

- In Ireland, the Sláintecare Report of 2017 proposes the phasing out of private practice in public hospitals over a 5-year period to end the unequal treatment of public and private patients in public hospitals. This proposal would mean that private care (mainly funded by private insurance) would only be accessible in private hospitals. Proponents of the reform hope that such a move would expand the capacity of public hospitals to treat patients, increase hospital activity and improve access to public services. A number of accompanying measures such as general capacity increases, targeted waiting time policies and a general reorientation of the care model towards primary and community care are also included in the Sláintecare reform proposals.
- In Israel, the current focus lies on better regulation for dual practice in different settings (the "outside" option using the typology above). As mentioned before, dual practice within the same setting is only feasible in some private for-profit and non-profit hospitals and regulations exist to limit private practice there. More urgent issues concern the exceptionally high growth of private patient activity in other private hospitals and associated problems: how to retain surgeons in the public system and increase their activity for public patients, how to use public facilities more efficiently and how to reduce private payments and slow down growth in private insurance premiums. The widespread use of duplicate insurance has led to a strong increase in private insurance spending and to a notable rise in private health insurance premiums in recent years (Rosen et al., 2015). Recent initiatives include additional funding to increase doctors' availability to treat public patients and to better protect patients that seek private treatment. Better regulation of the commercial private insurance market including a standardisation of duplicate insurance coverage is also on the agenda.
- In Australia, due to the complicated structure of hospital financing with mixed responsibilities between federal and state governments there are diverging interests with regards to private practice in public hospitals: state governments encourage public hospitals to carry out more private activity as this triggers additional and uncapped payments by other payers including from 'Medicare' - a federal scheme - thus relieving budget pressures from the states that are responsible for setting hospital budgets. The federal government, on the other hand, has raised concerns about inequity in access and is asking state governments to stop any practice of actively encouraging the treatment of private patients in public hospitals. These diverging interests highlight the fact that it is also important to understand the financial motivation of the various stakeholders when addressing the issue of private practice.
- In the United Kingdom, recent regulatory changes allowing NHS hospitals to generate considerably more private patient revenue led to a debate about the future direction of the system. Since the Health and Social Care Act was passed in 2012, NHS hospitals have been allowed to generate up to 49% of their income from private activity. Some health professional associations and other stakeholders have expressed concerns that this could eventually lead to a two-tier system where people with the ability to pay can get quicker access to services. Proponents of the reform suggested that the provision of private services in NHS hospitals would

meet a public need and this could be organised without limiting access to treatment for NHS patients (BMJ, 2012; BMJ 2013). At any rate, the proportion of private patients in all patients treated in NHS hospitals has remained small and unchanged since the regulatory change (BMJ, 2018).

- In France, private practice in public hospitals is regulated and monitored to avoid excessive extra-billing or time spent for private patients. It concerns relatively few physicians and, at the system level, it is not perceived as a major problem. There is no discussion about removing this activity at the moment. Yet, it is worth noting that most of private practice activity in hospitals occurs in private hospitals and is covered by social health insurance. There is no data available to assess whether patients in private hospitals are afforded faster access to treatment than patients in public hospitals. The main difference is that patients treated in private hospitals may expect more comfort but also extra-billing (often covered by complementary health insurance).

4. General assessment of private practice in public hospitals – the pros and cons

39. This chapter assesses the practice of treating private patients in public hospitals from a conceptual perspective. It highlights the potential benefits and costs of private practice, stresses the need to mitigate possible adverse consequences if a ban on private practice is considered and points to some information requirements to make such a decision. It shows that trade-offs exists between greater equity in treatment in the public sector and the costs associated with some unwanted effects of a ban of private practice. It does not give a final recommendation whether a country should allow or ban this practice – this depends on many additional country-specific factors. The chapter also discusses alternative and complementary policy options that Ireland or any other country could consider to address the unequal treatment of public patients and long waiting times.

4.1. Costs and benefits of private practice in public hospitals

40. In Ireland, the current policy debate on private/dual practice is focused on private practice in public hospitals. In terms of the last chapter's typology, this relates to the "within" and "integrated" cases of private/dual practice. More precisely, private practice in public hospitals generally refers to official arrangements that allow medical or related services to be provided on a private fee-for-service basis to patients by hospitals employees working outside their public-sector contracted standard working hours.

41. Conceptually, private practice in public hospitals can create a number of problems but also has its benefits. Compared to a situation when dual practice is allowed in the outside option only, it can create a number of adverse effects for the public provision of hospital services by undermining care responsiveness, distorting the use of physical resources, or adding pressure on hospital administration. It can also contribute to the erosion of public trust in the health system. Then again, allowing private activities in public hospitals can support human resource management by, for example, increasing the attractiveness of public employment conditions. It also enhances the choice of patients and increases public hospital income. The following subsections discuss these costs and benefits in greater detail.

4.1.1. Adverse effects of private practice in public hospitals

4.1.1.1 Reduced care responsiveness for public patients and distorted use of resources

42. Private practice in public hospitals may disrupt the operations of public hospitals – to the detriment of public patients. The main challenge for public hospitals in allowing private practice to operate on their premises is to efficiently use their resources - in particular the health workforce – while ensuring equal standards of care responsiveness for equal needs of public and private patients. As mentioned above, privately-funded activities in public hospitals are typically provided by consultants working outside of their contracted working hours. Consequently, hospitals need to be able to clearly distinguish between the regular and the extra working hours of the consultants. Time spent by other hospital staff, such as support staff, to service private patients also needs to be taken into account. In addition to workforce issues, one concern with private practice in public hospitals can be the diversion of equipment and supplies purchased for public patients to private patients, unless the cost of those is accurately accounted for in private patient fees.

43. In practice, establishing clear temporal boundaries in the use of resources for public and private patients might be difficult. In many countries, private activities should be delivered in the late afternoon and evening. In reality, the time boundaries can become blurred, with private patients also being treated in the morning (De Pietro, 2006). Moreover, consultants with different contractual working hours (e.g. full-time as opposed to maximum part-time) might start their private activities at different times in the late afternoon. Most importantly, episodes of care consist of a number of distinct activities, which need to be completed within specific time intervals. This means that private patients may be admitted to public hospitals during regular working hours. Consequently, private activities might create competition for time and attention of the consultants and the support staff to the detriment of public patients, who may experience reduced service availability and less responsive care with less attentive medical staff, having a negative impact on patient experience.

4.1.1.2 Additional pressure on hospital administration

44. Private practice in public hospitals requires hospitals to have more sophisticated administrative functions related to the provision of health care services. For example, in many countries, hospitals are obliged to have separate accounting systems for private activities, to prevent cross-subsidisation of private activities. Depending on the country, billing and insurance-reimbursement activities become more complex due to different payers. Variation in insurance claim processing procedures and coexisting coverage systems can also add to administrative costs (OECD, 2017a).

4.1.1.3 Erosion of public trust in the health system and inequity in access

45. Private practice in public hospitals may undermine the trust of the population in the public health system. Public trust in the health system is a complex concept depending on both facts and subjective perception. A range of qualities and attributes of the public health services has been shown to inspire trust, in particular, service reliability, responsiveness, and fairness (OECD, 2017b). The presence of private activities in public hospitals, and in particular the blurring between when public resources are available for private and for public patients, can negatively affect perceptions of the public health system's responsiveness and fairness. Moreover, in a system with two-tier waiting lists (different waiting list for public and private patients), waiting times are significantly longer for public patients, further undermining patients' trust in the public system (OECD, 2013).

4.1.2. Benefits of private practice in public hospitals

4.1.2.1 Increased attractiveness of public employment

46. On the other hand, allowing private activities in public hospitals also has potential benefits for access to and quality of care. In particular, it can support human resource management through:

- adding to the attractiveness of public employment conditions;
- facilitating hiring and retention of health professionals in short supply; and
- supporting development and training through higher volume of cases and diversity of services.[14]

[14] The types of service provided in private practice may differ from those provided for public patients.

47. These potential benefits were among the main motivations to allow private practice in Ireland, Australia, France, Israel and the United Kingdom. Moreover, in some countries, for example Italy, reforms intended to bring private activities into public hospitals by requiring publicly employed physicians to perform their private activity inside public hospitals' facilities. One intention of this reform was to better control for appropriateness, quality, and safety of the private health care services provided as most private hospitals and outpatient clinics were believed to have inadequate technology at the time when the reform was adopted (De Pietro, 2006).

4.1.2.2 Increased patient choice

48. Private practice in public hospitals also increases the choice of patients. In addition to having quicker access to care, patients choose private treatment if they prefer to be treated by the doctor of their choice or if they want a more 'comfortable' treatment. This can refer to a more upscale accommodation in case inpatient services are required, such as private rooms with a single bed and the possibility to receive visitors 24 hours a day, or to be able to choose the timing of treatment or examinations (De Pietro, 2006; OECD, 2013). While these amenities are frequently available in case of private treatment in private facilities, patients may also wish to have these choices in public hospitals.

4.1.2.3 Additional source of revenue for public hospitals

49. Finally, from a purely financial perspective, private practice can be an important additional source of revenue for public hospitals, as seen in Ireland and Australia[15]. In particular, in times when levels of public spending are uncertain and volatile, private patient income may contribute to the stabilisation of hospital revenues.

50. Table 3 summarises the main potential direct advantages and disadvantages of private practice in public hospitals. More system-wide effects a possible ban on private practice can have will be briefly discussed in section 4.3.

Table 3. Potential advantages and disadvantages from private practice in public hospitals

Private practice in public hospitals	
-	**+**
reduces access to care for public patients	makes public employment more attractive
reduces responsiveness of care for public patients	facilitates hiring and retention of health professionals in short supply
More complex and cumbersome hospital administration	contributes to development and training of physicians through higher volume and diversity of cases
erodes public trust (by creating inequities in access between public and private patients)	provides additional revenue for hospitals when public budgets are tight
	enhances patients' choice

Source: Authors' compilation.

[15] In Australia, this can vary from hospital to hospital as "public spending" at the hospital-level is set by the states.

4.1.3. Net effect of private practice in public hospitals unclear but might depend on governance

51. Some evidence to underpin the theoretical (dis)advantages of private practice in public hospitals is available. Some studies point, for example, to differences in treatment of private and public patients in public hospitals, frequently in low and middle income countries. A study in the Philippines, for example, found that self-payers and patients with private health insurance receive more care and have a higher likelihood to receive recommended services than public patients in public hospitals which could suggest better quality of care (James et al., 2015). For Ireland, more relevant than experience in low and middle income countries should be the situation in comparator countries. In Australia, a study found that private patients spend more time in Intensive Care Units and receive more procedures than comparable public patients but no differences in health outcomes such as inpatient mortality were found (Shmueli and Savage, 2014). With regards to access to service, available data from Australia confirms that public patients wait substantially longer for some interventions than private patients in public hospitals (AIHW, 2017).

52. Overall, it is difficult to draw strong conclusions from the evidence about the advantages and drawbacks of these arrangements in OECD countries. Most likely, findings indicate that the net effect might depend on the specific institutional arrangements and governance of the public sector – in particular the details of the public employment terms and conditions; whether these are effectively enforced; the mechanisms to enforce equal standards of access for equal needs; and the volume of the private practice as compared with the volume of the publicly funded hospital services (Socha and Bech, 2011; Araujo et al., 2016).

4.2. Phasing out private practice from public hospitals requires a careful approach to maximise the benefits and avoid pitfalls

Improvements to access and quality of care for public patients depends on how doctors react to the policy change

53. As discussed in the last section, phasing out private practice in public hospitals could potentially improve access and quality of care for public patients if such a move leads to an increase in the time available for the treatment of public patients.

54. One outcome of a ban on private practice would be that public hospital consultants progressively transfer their private activities to private hospitals. Such arrangements would ease the management of public hospital services and provide consultants with greater freedom and autonomy when providing private services. Still, there would be a need to ensure that the consultants engaged in private practice *outside* public hospitals fulfil the contracted working hours in the public facilities.[16] In the state of Queensland in Australia, for example, a recent audit found the lack of monitoring of working hours of Senior Medical Officers engaged in private practice to be an issue of concern (Queensland Auditing Office, 2013). In Ireland, too, recent reports suggest compliance with these contracts is lacking oversight with consultants spending much less time in the public sector than contractually required (RTE, 2017). Measures to improve monitoring of working hours of doctors in public hospitals are also on the agenda in Israel.

[16] Literature on dual practice frequently discusses the cases of public hospital consultants being absent during their contracted working hours – a phenomenon usually associated with the fact that many of them practice also in the private sector. The reported evidence refers mainly, however, to low and middle-income countries. There are also other reason why public hospital employees have been found to be absent during regular working hours, such as various family and household-related obligations.

Ensuring attractive employment conditions in public hospitals limits the risk of public sector health professionals moving to the private sector - or simply the risk that activity would not increase in public hospitals

55. While a ban on private practice in public hospitals would, *ceteris paribus*, lead to more physical capacity available to treat public patients (more beds/equipment will be available exclusively for them) whether it improves access for public patients is not guaranteed automatically as the total number of health workers in the public sector may fall (assuming pay and other working conditions in the public sector do not change); or simply the supply of services would not increase in line with increased available capacities (if the same number of doctors work same length of time as before) – de facto leading to a shift in private activities from public hospitals to private hospitals but not to any increase in public hospital activity.

56. Without the option to engage in private activities, employment in public hospitals might become relatively less attractive as compared to the private hospital sector, in particular for the most senior and qualified doctors. Even if private practice is transferred to private hospitals, the necessity to balance work commitments between two separate employers (or two separate contractual arrangements) and physical locations could create significant disincentives to remain in the public sector (Socha and Bech, 2011; Araujo et al., 2016). If the private sector is not big enough to absorb a discontented public workforce, doctors might consider looking for alternative employment abroad.

57. Hence, staff retention in the public sector may become a problem potentially leading to a reduction in the available health workers to treat public patients. This might particularly affect general public hospitals, which - in contrast to academic hospitals - cannot offer additional employment benefits such as prospects of engaging in research or opportunities for development and training through high volume and diversity of cases. Moreover, in most countries the private hospital sector tends to concentrate in the larger agglomerations. Hence, phasing out private practice in public hospitals might strengthen incentives for health professionals to migrate to larger cities. Consequently, public hospitals in rural areas might encounter problems with maintaining adequate staff levels, especially for health professionals in short supply. Thus, staff shortages might translate into limited access to hospital services and negatively affect quality of care. And, again, even without falling staff levels, the supply of services and activities in public hospitals may not increase if the number of doctors and their working hours remain unchanged.

58. Whether staff shortages in public hospitals as a result of a ban are a realistic scenario in Ireland is unclear. It largely depends on whether private hospitals offer valid alternative employment opportunities and if a move abroad is a credible option. With everything else equal, demand by private hospitals for qualified health workers may rise if patients want to continue to use their private health insurance for treatment after the ban. However, if waiting times in the public sector are reduced because of an increase in capacity (assuming conditions are such that an increase in activity occurs), fewer people may want to go to private hospitals.

59. Moving abroad has always been an option of Irish doctors –even before this reform has been considered. However, for young doctors – who are typically the ones considering migrating – a ban on private practice in public hospitals will not change current working situation as they are not allowed to engage in it in the first place. Whether the *prospect* of never being able to engage in it is a credible concern is unclear. Since average salaries of employed specialists in Ireland are higher than in most other countries, finding a more lucrative country to exercise this profession could be difficult. Yet, financial considerations are typically only one of many elements when deciding whether to pursue a career abroad.

60. Raising salaries of doctors in exchange for foregoing the right to private practice and thus increasing their availability for public patients has been a measure taken in a number of countries, including Portugal, Spain and Italy to address this problem in the past (Garcia-Prado and Gonzalez, 2007). The 'full-timer initiative'[17] in Israel is also going in this direction (Rosen et al., 2015).

Restoring public trust in the health system requires complementary policies

61. Phasing out private practice could potentially contribute to restoring the trust in the public health system if waiting times in the public sector are reduced as a consequence. Yet, to achieve this, additional measures such as an increase in capacity or better waiting list management might be needed.

Close consultation with the main affected stakeholders can help mitigate potential adverse consequences

62. In order to mitigate the potential adverse consequences of removing private practice from public hospitals, such a policy change should be planned and implemented in close consultation and co-operation with the affected health professionals and other stakeholders.

63. In particular, it is essential to identify the characteristics that make private practice in public hospitals attractive for hospital consultants. The information on these characteristics and their relative importance can be used to design more attractive and motivating employment packages to retain health professionals, improve their performance in the public hospital sector, and raise activity and supply.

64. The situation in the private hospital sector, in particular the capacity and geographical distribution of the private facilities and the potential for their expansion, should also be evaluated.

65. All possible stakeholders that could be affected by such a change should be mapped out and their interests analysed. This stakeholder landscape may be complex going beyond those listed above: In Australia, for example, the state governments encourage their public hospitals to engage in private practice as it triggers additional revenues while the federal government would like to see it reined in to tackle inequalities.

66. The decision of whether to ban private practice from public hospitals is a complex one and whether the potential benefits of such a ban outweigh the risks depends on a number of country-specific factors. A roadmap detailing the information requirements could help in making such a decision. In particular, there is a need to collect and/or analyse information on:

- the proportion of income from private activities in the total income of the public hospitals employees;
- the importance of additional career opportunities that private practice offers to consultants (e.g. gaining experience more quickly, and providing services different than an exclusive practice in public sector would allow);
- the likelihood of health workers to pursue careers abroad;
- the capacity and geographical distribution of private hospital facilities, which could potentially compete for the public hospitals staff – this should include analysis of

[17] The currently planned 'full-timer initiative' aims to reduce waiting times in public hospitals and to better utilise public resources. In exchange for a significant pay raise, physicians in public hospitals will be asked to work additional hours in public hospitals and agreed not to do additional work in private hospitals to reduce waiting times for elective surgery and ambulatory treatment in the public sector.

potential for geographical expansion of the private hospital facilities, e.g. outside the largest agglomerations;

- the motivation why some patients with private insurance want to be treated in public hospitals instead of private hospitals and vice-versa, and analyse whether the perception of clinical and/or service quality drives the decision;
- the terms and conditions of the public employment in so far as the rules for engaging in private practice outside public facilities are concerned;
- the possible ways to fill in the capacity left void in the public systems (e.g., by employing more doctors, lengthening the working time of contracted doctors) and the associated implications (e.g., number of extra posts to be filled in; management of changes in the staff working part-time vs. full-time; any extra-time doctors might need to do).

4.3. Wider impact of possible ban of private practice in public hospitals

67. In addition to the consequences displayed in the previous section, a possible ban on private practice could also have more system-wide consequences on particular sectors. Two areas of the health system that would most likely be affected are the hospital sector and the insurance market. However, again, how these sectors could develop as a result of such a reform would also depend on to what extent complementary measures are taken.

The hospital mix may change as a consequence of a ban on private practice

68. The effect of a possible ban of private practice in public hospitals on the hospital landscape will depend on a number of factors: (i) can the 'freed-up' private practice capacity be immediately used by public patients; (ii) what waiting times policy will be implemented; and (iii) will there be ongoing demand for duplicate insurance in private hospitals. If the latter is true, private hospitals will have an incentive to increase their capacity. The private hospital associations typically support the ban or restriction of private practice in public hospitals as seen in Ireland (PHA, 2018) or Australia (APHA, 2017).

69. Trends in OECD countries regarding the mix of public and private capacity reflect the history and health policy priorities of countries (Box 1).

Box 1. Trends in the private/public mix in the hospital landscape in OECD countries

The private/public mix is mainly influenced by the nature and the history of a health system and its policy priorities. In that respect, OECD countries have taken many different directions and the current landscape is mixed. In Germany and France, competition between public, private for-profit and not-for-profit hospitals has been encouraged and the resulting hospital mix reflects this reality. In other countries, such as Spain or Israel, the share of beds in public hospitals has increased. In the Netherlands, regulations require hospitals to be in private ownership but of a not-for-profit status. Generally, a trend towards a higher involvement of the private sector in inpatient care delivery can be observed. However, ownership does not seem to be the decisive factor for hospital performance. More important appears to be the structure in which these hospitals operate (OECD, 2012b). This refers, for example, to the regulatory framework but also how hospitals are incentivised to provide care efficiently or whether purchasing is split from care provision. A number of countries have implemented significant hospital reforms in recent years that have seen some success in improving performance: Denmark, for example, pursued the centralisation of hospitals in the wake of wider administrative reforms (Christiansen and Vrangbæk, 2018); in Japan, all national hospitals were reorganised into a single entity but allowed to operate more autonomously with expanded authority and responsibility.

That said, a general observable trend is a reduction of the hospital bed density in most OECD countries, accompanied by initiatives to strengthen primary care to avoid hospitalisations. Against this general trend some few countries including Korea and Turkey have increased hospital capacity in recent years by mainly relying on the private sector.

A ban on private practice in public hospitals may also affect the insurance market

70. A possible ban on private practice in public hospitals will most likely have repercussions on the private health insurance market. The main insurance policies in Ireland currently provide duplicate coverage to have quicker access to diagnosis and hospital treatment. A ban on private practice in public hospitals will drastically limit the number of providers where this insurance policy can be used. The future demand of this insurance product will also depend on how this reform plays out: if public hospitals are able to use the "freed-up" capacity to reduce waiting times for public patients then the demand for private voluntary health insurance would decline. However, these policies will remain in demand if private activity shifts from the public to the private facilities, such that private capacity can absorb these new cases, and if there remains significant differences in waiting times for treatment or other advantages.

71. The relationship between demand for private insurance and supply of public and private health care is very complex and country-specific. Analysing data from the United Kingdom, Biro and Hellowell (2016) find a positive association between PHI coverage and region-specific NHS waiting times. Yet, over time an increase of private inpatient health care supply is associated with a decrease in PHI coverage and NHS waiting times. This result may be explained by higher contracting volumes of NHS services with private providers making public services more accessible and thus disincentivising the purchase of PHI coverage.

4.4. Alternative or complementary policy options to a ban on private practice in public hospitals that could be considered in Ireland

72. This section describes some alternative policies that could be pursued to address unequal treatment of public and private patients and long waiting times in the public sector which could be implemented either alongside or instead of a ban on private practice.

4.4.1. Addressing capacity issues

73. The international comparison in Chapter 2 showed that, on a per capita basis, Ireland has around 40% fewer hospital beds than the OECD average. Hence, one possible option that Ireland could explore is to increase the capacity of the public hospital sector. This recommendation is also included in the recently published capacity review (Department of Health, 2018b). It is expected that such a measure would bring down waiting times for public patients – under the condition that staff levels will not fall in public hospitals. Thus, an increase in the capacity would need to go hand in hand with measures to retain and recruit new workforce.

4.4.2. Public contracting of private hospitals

74. One way of tackling the unequal treatment of patients in public hospitals and address waiting times is to remove the difference in the financial incentives to treat public and private patients. For such a system to work the following conditions need to be met:

- Public and private hospitals receive payment for all medical services, medicines and other items through a uniform fee schedule, regardless of the coverage status of the patient;
- The fee schedule prohibits charging patients a fee higher than the specified fee for services reimbursed by the public system;
- All hospitals must provide medical services within the framework of the items and fees specified (for publicly reimbursed services);
- All hospitals organise planned admissions through a unique waiting list.

75. The creation of a level playing field in care provision would also require the public contracting of private providers and hence the removal of the strict separation between the public and private sector. Many OECD countries have a long history of public payers contracting private hospitals to deliver services. In recent years, more OECD countries have drawn on the private sector as part of efforts to deliver universal health coverage (Kumar et al., 2014). For Ireland, this would mean that private hospitals would be able to contract with the HSE to provide services to public patients. Such a shift would increase the physical capacity for the treatment of public patients immediately. If a universal price for all patients is set – to be applied by public and private hospitals - than the financial incentive for a preferential treatment of private patients is removed. This would lead to a more equal treatment of patients and could bring waiting times for public patients down.

76. A number of European countries have introduced fixed prices per patient encouraging hospitals to compete on quality but they differ in the way prices are set and administered (Siciliani et al., 2017). In the Netherlands, the combination of allowing competition and choice for patients with the introduction of activity-based financing, lifting a cap on hospital spending and introducing waiting time norms has led to the successful elimination of waiting times (OECD, 2013). In general, it appears that a combination of sufficient supply, payment systems that reward activity for both specialists and hospitals, and limited constraints on hospital spending are associated with low waiting times. However, these policies tend to be expensive. A similar approach that has been

successful in Portugal and Denmark is to allow patients to choose alternate health providers, including from the private sector, if patients have to wait beyond a maximum time.

4.4.3. Additional policies to target waiting times

77. If enforced, waiting time guarantees can be successful in reducing waiting times. Besides increasing the choice of patients and introducing competition between hospitals, setting waiting time targets and holding health providers to account for achieving the targets is a possible policy option. This approach has brought waiting times down in Finland and the United Kingdom. However, it has proven challenging to sustain this over a long time (OECD, 2013).

78. Demand-side polices can be a complementary approach to reduce waiting times in order to reduce or shift the demand for elective treatments. Improving the clinical prioritisation for elective treatments is one approach, and can be linked to waiting time guarantees, with different guarantees depending on the level of need. This appears to be a promising approach, but requires better tools for clinical prioritisation that measure reliably clinical need and the benefit of the elective procedures (OECD, 2013).

5. Conclusion

79. This paper described the potential benefits and costs of private practice in public hospitals and discussed possible consequences a ban on private practice could entail drawing from selective experience from OECD countries and a review of the published literature. It is aimed to support discussion around a possible policy change in Ireland.

80. This paper does not give recommendations on whether such a ban should be implemented or not. Such a reform would eliminate the unequal treatment of patients in public facilities, but whether it actually reduces waiting times for public patients and the wider impact of such a reform depends on wider conditions and features of the system – for example, policies to ensure increase in supply of services in public hospitals, how contractual arrangements with providers are managed, wider issues around the attractiveness of practice in public hospitals, the adequacy of information systems to monitor impact and the management of the reform process including engagement and involvement of relevant stakeholders. There are likely to be many repercussions in the system, and properly assessing how patients, doctors, public and private hospitals or insurers will react to such a policy change will be key. The overall impact will also depend on the extent to which complementary reforms – as recommended in the Sláintecare reform proposal - will be implemented.

81. The paper points to some key information that should be collected in order to make an informed decision on whether to ban private practice in public hospitals. For example, it is vital to better understand the motivation of doctors for engaging in private practice in public hospitals. The paper also stresses the need to mitigate any potential adverse effects if a ban on private practice is pursued, for example by re-evaluating the employment package of physicians and strengthening the monitoring of dual practice arrangements. In the end, there are likely to be trade-offs to be resolved and considered, for example between improved equity in service provision in public hospitals and the costs of some potential unwanted side-effects such as reduced service availability if adequate policies are not put in place to fill in the vacant capacity. Given the likely disruption to the system an orderly transition is crucial if a reform is pursued. Careful service and capital planning across sectors is also required, along with a close consultation and co-operation with the affected health professionals and other stakeholders.

82. Alternative or complementary options could also be considered to tackle the key concerns of long waiting times and unequal treatment in public hospitals – some of them also mentioned in the Sláintecare reform proposals. Possible options could be an overall increase in capacity, allowing HSE to contract private providers for public care provision, giving patients more choice of providers or introducing a waiting time guarantee for patients.

83. As the case studies in this paper show, the organisation and regulation of private practice varies across countries but is generally complex. The extent to which the simultaneous treatment of public and private patients in public hospitals creates system-level problems also differs between countries. These case studies also show that even if a ban on private practice in public hospitals is implemented appropriate regulation and governance of dual practice of publicly employed physicians who treat private patients in private settings remains essential.

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Annex A. Ireland

Coverage

84. Ireland's health system is a national health service funded predominantly through general taxation. All Irish residents are entitled to a range of services in the public system including inpatient and outpatient care in public hospitals. Coverage for GP visits is means-tested and currently limited to around half of the population who either have a "Medical Card" or a "GP Visit Card". In addition, around 45% of the population have voluntary private health insurance, mainly for quicker access to care.

Service delivery

85. Health services are provided by a mix of public and private providers. Primary care is generally provided in private solo or groups practices. Outpatient specialist services are mainly provided in outpatient departments of hospitals.

Hospitals

86. There are three types of hospitals in Ireland: two are publicly financed hospitals – either 'state-owned' and managed by the Health Service Executive (HSE), or privately-owned and managed by autonomous bodies such as charities and called 'voluntary public hospitals'; and private hospitals, which typically do not receive public funding besides through the National Treatment Purchase Fund (NTPF) which purchases private hospital services for those patients who have been on the public waiting list for too long. The 50 or so public hospitals (including both the state-owned and voluntary public hospitals) are organised into 7 hospital groups. In addition to acute inpatient services, hospitals also provide outpatient specialist treatment for which a GP-referral is needed. In public hospitals, patients can choose to be treated as private patients for both inpatient and outpatient services. As private patients they have to pay the costs for accommodation and consultancy fees – in most cases people have private health insurance to cover those costs.

Hospital Payment

87. Since 2016, inpatient and day case activity have been paid for on a case base called 'activity-based funding (ABF)'[18] in public hospitals; all other activity (emergency departments, outpatient) are financed via block grants. The overall hospital budget is set by the Minister whereas the HSE agrees to performance contracts with the different hospital groups defining costs and volume thresholds. Additional activity needs to be approved and may be paid at different (reduced) rates. The actual payment to the hospital is based on the submission of claims (Health Pricing Office, 2015). Private hospitals can set their own prices based on agreements reached between hospital and private insurers.

Treatment choice for patients in public hospitals

88. For public patients, hospital outpatient services are free of charge if they have a referral by their GP. If emergency departments are visited without referral a EUR 100 charge applies. For inpatient services, public patients have a co-payment of EUR 80 per day capped at EUR 800. Some

[18] ABF is based on the Australian DRG system 'AR-DRG'

exemptions exist for low-income patients. Private patients have to pay the consultant's fee for the services rendered both in an outpatient and inpatient setting. For inpatient treatment, there are additional daily charges for private patients to be made to the hospital. The actual amount depends on the hospital (there are 2 categories) and whether accommodation is in a room with single occupancy, multiple occupancy or treatment is on a day care base. For the more expensive hospital category, these charges are (in 2018) between EUR 407 (day care) and EUR 1,000 (single room) per day. These charges were introduced in 2014 to stop the subsidisation of private patients by public funding. Most patients who want to be treated as private patients have voluntary health insurance that covers the costs for these services – at least partially. Hence, the treatment of private patients is financially beneficial both for the hospital and for the consultant, providing an incentive to treat them.

Regulation of private practice

89. Regulation of private practice in public hospitals has been a long-standing issue in Ireland (McDaid et al., 2009). From a hospital perspective, private practice was regulated before 2014 by defining a quota of 20% of beds in public hospitals designated for private patients but many hospitals surpassed this threshold (O'Reilly and Wiley, 2010). The rationale for this public/private mix was to ensure that the public and private sectors can share resources, clinical knowledge, skills and technology (Department of Health and Children, 2001). Since 2014, this quota no longer exists and patients need to declare whether they want to be treated as private or public patients upon admission. A clear separation between beds for the treatment of public and private patients no longer exists and private patients are required to pay for accommodation regardless of the type of bed they use. As a result of this reform the private patient income in public hospitals has jumped by 20% in 2014 compared to the previous year (Department of Health, 2017). Since the reform, there have been some concerns that public hospitals have been encouraged to generate additional revenue from private patients to reach specific private patients income targets (The Irish Independent, 2014).

90. From the perspective of the physician, only senior doctors categorised as "consultants" are allowed to treat private patients. In 2016, this referred to around a third (2,862) of all doctors in public hospitals (Department of Health, 2018a). Whether consultants in public hospitals are allowed to engage in private practice depends on their consultant contract[19] with the Health Service Executive (Woods, 2017):

- Type A contracts restricts consultants to work in the public sector;
- Type B permits consultants to treat private patients in public hospitals up to an agreed limit which may not exceed 20%;
- Type B* are contracts for doctors employed before 2008 who are allowed to engage in private practices off-premise;
- Type C permits consultants to see private patients in either public or private hospitals in addition to their obligation to see public patients.

91. As of 2017, the vast majority of consultants are allowed to engage in private practice: 66% hold a Type B contract, 28% a Type B* or Type C contract and only 6% a Type A contract (Woods, 2017). The contract stipulates that consultants with the permission to engage in private practice have to fulfil their obligation to work 37-39 hours a week for the public sector. While at a national level the share of public patients in public hospitals stood at 82% for inpatient elective surgery and

[19] The most recent framework for this is the 2008 Consultant Contract.

85.8% for day case, there is more variation at a hospital level (Woods, 2017). Yet, recent reports suggest compliance with these contracts is lacking oversight with consultants spending much less time in the public sector than contractually required (RTE, 2017). The negotiation of the 2008 Consultant Contract has resulted in a significant salary increase for consultants in exchange for increasing the number of weekly hours for the treatment of public patients from 33 to 37 and the commitment that at least 80% of their clinical output must be for public patients (McDaid et al., 2009).

Private Health Insurance

92. The fact that around 45% of the population has voluntary ("duplicate"[20]) insurance mainly to cover private patient treatment is important to understand in the context of private practice. There are currently three private insurers in the market, plus some additional restricted schemes. "Vhi Healthcare" is by far the biggest insurer accounting for 50% of all policy holders (Health Insurance Authority, 2018). All policies have to include a minimum of benefits. Depending on the insurance policy, the costs of private *inpatient* treatment – that is, consultant fees and accommodation - in both public and private hospitals are typically covered entirely by private insurance. For private *outpatient* treatment, patients may have to pay part of the costs themselves (McDaid et al., 2009). Interestingly, since changes introduced in 2014, voluntary insurance policies typically do not provide much additional benefit in a public hospital, apart from choice of consultant and, linked to this, the possibility to have quicker access to treatment. Single-room occupancy is frequently not available. Regardless of the lack of additional services compared to public patients, the hospital still has to charge the rate for private patients. Yet, this legislative change does not appear to have had an influence on demand: the public/private composition of public hospital discharges has remained unchanged after the implementation of the reform (Department of Health, 2017).

Waiting times

93. Waiting times are a persistent issue in Ireland and many reforms in the past have tried to reduce them – with limited success. A number of key performance indicators monitor the achievement of waiting time targets within the HSE for acute and primary care (Health Service Executive, 2017). Results for 2016 show the extent of the problem which appears more urgent than in most other OECD countries, for example:

- only 91% of all adult patients are treated for an elective inpatient procedure within 15 months (down from 97% in 2015);
- only 81% of all adult patients wait less than 52 weeks for first access to outpatient department services (down from 90% in 2015).

94. Moreover the differences between waiting times in the public and private system can be striking, for example for diagnostics to detect cancer (O'Shea and Collins, 2016). In addition to the potential impact on quality of care and health outcomes, the unequal treatment has equity implications.

[20] "Duplicate insurance" provides coverage for services already covered in the public benefit package but increase the choice of providers (e.g. private hospitals) and/or the choice of doctors mainly to avoid waiting times in the public system.

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Annex B. Australia

Coverage

95. The Australian health system is a complex mix of federal and state government funding and responsibility, interspersed with services delivered through the public and private sectors. Australia has a universal health system funded through the Medicare scheme. It is mostly financed through taxation and entitles Australians to free care as public patients in public hospitals. Among other things, it also entitles people to 75% of the Medicare Benefits Schedule (MBS) fee for all services and procedures during an admitted episode of treatment for private patients in a public or private hospital (not including hospital accommodation and items such as theatre fees and medicines).

96. While public hospitals are jointly funded by the federal and state and territory governments, their administration and performance is the responsibility of the states and territories as system managers. The Australian Government plays a role in policy making and monitoring with regards to public hospitals, but does not provide the services.

97. Private health insurance is voluntary in Australia and the uptake is subsidised by the government. It mainly increases the choice of providers (including private hospitals and choice of doctors), provides faster access to non-emergency services and provides rebates for selected services. There are different types of insurance policies for different needs. In 2016, 47% of the population had private hospital coverage, either with a policy covering hospital treatment only or with a policy combining hospital treatment and general treatment. Given that taxpayers have the right to be treated in public hospitals as public patients, people with additional voluntary PHI can choose to be treated as either public or private patients in a public hospital or as private patient in a private hospital (under certain conditions the treatment of public patients in private hospitals is also possible). These different treatment options have wider implications for hospital financing and care organisation.

Specialist services

98. Specialist services are provided in private practices or public hospitals. Specialists are paid on a FFS base and can set their own fees. In an outpatient setting, Medicare covers 85% of the MBS fee with the remaining part being covered by private insurance and out-of-pocket. Many specialists split their time between the public and private sector.

Hospitals

99. In 2015-16 there were 1,331 hospitals in Australia with 53% of them being public and 47% private. Public hospitals are typically larger and hence 65% of all beds are located there (35% in private hospitals). There has been a shift towards private capacity recently: While the overall number of hospitals has decreased over the last decade the number of private hospitals has increased. The number of beds has increased for both types of hospitals but grew stronger in private institutions.

100. When it comes to activity, hospitalisations of private patients in both public and private hospitals outgrew (5.6% annually) those of public patients (3.1%) in recent years. As a result, patients funded by PHI represented 42% of all discharged patients in Australian hospitals in 2015-16, up from 36% in 2006-07. The growth was particularly strong in public hospitals: hospitalisations funded by PHI made up 13.9% of all hospitalisations in 2015-16, up from 8.2% in

2006-07, which represents an annual increase of 9.6% (the biggest increase was in emergency admissions +11.7% p.a.). Admissions in private hospitals only grew moderately by comparison (+4.9% p.a.).

101. In 2015-16, public hospitals were mainly funded by the federal government (39%) and states (53%) with the remaining part coming from private sources. Private hospitals are predominantly funded from private sources (68%). Funding for both sets of hospitals have increased since 2011-12 but spending for private hospitals grew faster (6.0% vs 3.2% annually, adjusted for inflation).

Hospital payment

102. Public hospitals are funded by complex mechanisms involving the federal government, the states and other payers. Generally, they are financed on an activity-basis using DRG with service mix, volumes and state pricing determined at the state level. The federal contribution for public hospital services is based on a national activity-based funding system with pricing determined by an independent Hospital Pricing Authority, with different rates for public and private patients. In addition to the discounted ABF rates from the federal government public hospitals receive other sources of revenue for the treatment of private patients, such as Medicare, private insurers and patient out-of-pocket contributions. Private hospitals are mainly funded on a fee-base.

The choice of patients

103. Patients can choose to be treated in public or private hospitals. In public hospitals, patients are to elect whether they want to be treated as public patients or as private patients at the time of admission or as soon as possible after:

- As an admitted public patient, all treatment costs will be covered by Medicare including accommodation and costs of doctors. Waiting times for elective surgery as a public patient are dependent on a number of factors, including clinical need, levels of service provisions, and the number of patients requiring that service.
- As an admitted private patient in a public hospital there could be co-payments depending on the fees set by the treating doctor as not all costs will be covered by Medicare. For admitted services, Medicare will cover 75% of the MBS fee with the remaining part either fully or only partially covered by any PHI. Costs for accommodation charges are set by the states and need to be covered by PHI or the patient.
- For private patients in private hospitals the situation is similar than for private patient in public hospitals.

Employment of doctors in hospitals

104. Practice patterns for specialist differ between states. Across Australia, a 2013 study finds that 33% of specialists only work in the public sector (but may treat private patients there), 19% only work in private facilities and 48% have mixed practice (Cheng et al., 2013). Doctors working in public hospitals are either publicly employed or self-employed. Those who are publicly employed receive a salary and specialists are typically allowed to treat private patients in the same hospital (this is not true for more junior 'non-specialists' without post-graduate training). For this private activity they can charge patients on a fee-basis but may have to transfer at least some part of the fees to the hospital (they may also forego the right to bill themselves and let the hospital

handle this in exchange for a higher salary). Self-employed doctors working in a public facility will also be paid on a fee-basis for their services (they are allowed to keep their income but may have to pay the hospital for the use of facilities). Hence, dual practice is common in public hospitals.

105. Regulation of private practice and employment contracts are the responsibility of the states. In the state of Queensland, for example, the current agreement allows Senior Medical Officers (SMOs) to work their contractual 80 hours per fortnight in maximum shifts of 10 hours per day each (SMOs may also have part-time contracts). Beyond this, SMOs can use their time as they wish – which can be additional work in private facilities. The majority of SMOs have the right to treat private patients (RoPP) in public hospitals and either get an allowance or retain parts of the fees charged to the patients (Option A or Option B contracts). They are allowed to treat private patients in their rostered hours if

- it does not affect the treatment of public patients
- patient treated by SMOs are seen on SMOs approved hospital campuses
- billing is done by HHS (Hospital and Health Services- a statutory body) and revenues shared between HHS and SMOs

106. But physicians can also treat private patients outside of their rostered hours in the same public facility. A recent audit found a number of problems with the RoPP in Queensland in particular a lack of transparency and oversight of workplace attendance of SMOs and accountability (Queensland Audit Office, 2013).

Motivation of private practice in public hospitals

107. The motivation behind allowing private practice in Australia needs to be understood against the background of the complex mixed hospital financing arrangements.

108. States encourage public hospitals to generate additional revenue from private practice. In fact, states may set out private patient revenue targets for public hospitals. The reason for this is simple: private patients bring in additional funding from other payers - funding that is not capped by hospital budgets. In 2012, the treatment of private patients in public hospitals generated approximately AUD 1,371 mn, consisting of the following components (King, 2013):

- AUD 864 mn accommodation costs payable to hospitals (either by PHI or OOP)
- AUD 384 mn fees payable to doctors of hospitals (partly by Medicare, the rest PHI or OOP)
- AUD 123 mn prosthesis to hospitals (by PHI)

109. Hence, hospitals try to encourage patients to elect private status when they enter the hospital. For physicians, engaging in private practice is a way to top up their public salary by charging additional fees for private patients (even if they pass on parts of the fees to the hospital). Patients can choose their surgeon and may get a single room and do not have to wait on public patient waiting lists for elective surgery.

110. PHI has limited levers to restrict private practice in public hospitals. Policies are regulated and insurers are not allowed to 'punish' those policy holders that choose private practice by individually adjusting their premiums. They need to collectively raise premiums instead.

111. Without the support of the states the federal government can also do little to limit private practice. The introduction of ABF on a national level in 2014 can be understood as an attempt to

eliminate the price differences between public and private patients but since hospital prices and budgets are set at a state level their possibility to influence financial incentive is limited.

112. Although increased choice of provider or surgeon is the main policy argument for private insurance, in practice it seems to be more about reducing waiting times. A recent report by AIHW highlighted substantial differences in waiting times between private and public patients in public hospitals (AIHW, 2017). For example, the median wait times for patients admitted from public hospital waiting lists was

- Cataract: 113 days (public patient) vs. 29 days (private patient)
- Total hip replacement: 125 days (public patient) vs. 53 days (private patient)
- Total knee replacement: 203 days (public patient) vs. 76 days (private patient)

113. Based on these findings the federal government reiterated their concerns about inequity in access and asked state government to stop the practice of actively encouraging the treatment of private patients in public hospitals (MoH, 2017).

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Annex C. France

Coverage

114. The French population is covered by social health insurance. Funding of social health insurance is based on income-related contributions from employers and employees and government transfers. Nearly the entire population has additional voluntary health insurance coverage which mainly plays a complementary role – covering the cost-sharing obligations for patients for services financed by the social health insurance scheme.

Service delivery

115. Health services are provided by a mix of public and private providers. Primary care is generally provided in private solo or group practices. Outpatient specialist services can be provided in private practices or hospitals.

Hospitals

116. In France, private for-profit hospitals contribute to health care delivery, in competition with public or private not-for-profit hospitals. Although all hospitals are allowed to provide all types of health care services covered by social health insurance (with an exception for emergency services, which are mainly public), the three types of hospitals focus on different activities: acute care services (medicine, surgery and obstetrics) are mainly provided and equally shared by public and for-profit private hospitals, while public and not-for-profit hospitals are the main providers of psychiatric care. All types of hospitals contribute to the provision of rehabilitation services. Private hospitals accounted for 23% of all hospital spending in 2015, unchanged from 2006 (Ministère des Solidarités et de la Santé, 2017).

117. Before 2004, private for-profit and public hospitals were paid differently (per diem + fee-for-services for private hospitals and global budget for public or not-for-profit hospitals). In 2004, a reform introduced DRG payments for acute care services for all types of hospitals, progressively for public and not-for-profit hospitals until 2008 and at once for for-profit hospitals in 2005. DRG tariffs differ according to hospital status: firstly, because the fees of private physicians working in private-for-profit hospitals are not included in DRG tariffs for this sector- they are paid separately- but also because the convergence of tariffs, initially part of the reform, was subsequently abandoned.

118. DRG tariffs account for 78% of hospital payments for acute care services. A number of high-cost medicines or medical devices are paid on top DRG payments (8.4% of total payments). Besides DRG payments, hospitals get annual flat rates for some activities (2.4%) and additional payments for some missions of general interest (11%). Psychiatric services are still financed through global budget in the public sector and through per diem in private-for-profit hospitals. Rehabilitation services are paid through a mix of global budget and activity-based funding.

Co-payments in hospitals

119. In the French system, cost-sharing with social health insurance for hospital services is relatively high in comparison with other countries but this is largely covered by complementary health insurance. The main co-payment for acute care services refer to cost-sharing of 20% (not applicable for diagnostic or surgical procedures whose cost exceed the threshold of EUR 120), and co-payments of EUR 20/day for acute in-patient care and EUR 15/day in psychiatric facilities.

120. In addition, patients may have to pay supplementary charges for a private room. Most physicians in private-for-profit hospitals charge extra-billing over SHI fees. All these supplements are not covered by social health insurance but very often covered – at least partially – by private health insurance.

121. In 2015, social health insurance financed 91.4% of the costs of hospital care, with voluntary health insurance (5.1%), patients (2.3%) and the government (1.2%) funding the remaining part. Due to differences in the range of activities and extra-billing practices, the share of social health insurance in hospital financing is slightly higher in public (92%) than in private hospitals (89%).

Hospital employment

122. In 2016, 68% of all physicians in the hospital sector (including interns) worked in public institutions with the rest being split between the private for-profit (21%) and not-for-profit sector (11%). The overwhelming majority of hospital physicians are full-time salaried workers employed by hospitals. In this context, there are however a few exceptions:

- Some physicians combine a part-time hospital activity and a private practice.
- Under specific circumstances, private practitioner can be contracted by public hospitals to deliver services (this possibility was expanded in 2009 to support public hospitals which face difficulties in hiring doctors to deliver on specific obligations).
- Finally, and this is the main mechanism reviewed here, some physicians who are full-time employees of public hospitals are allowed to deliver services on a private basis.

123. Compared to other countries, private practice by public sector physicians in France appears to be comprehensively regulated and its scope limited. It was introduced in 1958 and always seen as a policy to support the retention of highly qualified staff in the public sector. In 2013, the then-Minister commissioned a review on private practice in public hospitals (Ministère de la Santé, 2013). The main objective of the review was to adapt to this sub-sector a system-level policy priority of the time which was to curb balance billing in the system. More broadly, the review was also to suggest ways to monitor how the regulation of private practice could be better enforced. Consequently, some recent legal modifications have reinforced the monitoring of private practice in public hospitals. In 2016, a legal change created an obligation of agreement with the social health insurance for each physician engaging in private practice activity.

124. Today, the main rules in place are the following:

- A physician wishing to have a private practice must sign a contract with the hospital (valid for 5 years) and this contract needs to be approved by the regional health authority (ARS).
- The activity must not exceed 20% of the statutory worktime and the volume of services provided in this context must be lower than the volume delivered for the public sector.
- No bed or equipment can be dedicated to this private practice and this work must not create a burden on public-sector colleagues.
- The public hospitals in which these providers operate must put in place a “charter” outlining the principles guiding this practice which in particular must highlight the right of patients to obtain public services. They also must put in a place a private practice commission which monitors the private activity of their employees and ensures the compliance with the regulatory framework described here.

- The fees charged for private services must be displayed and explained to patients, the patients hospitalised for private services must sign a clear consent form.
- Physicians must pay back to the public hospital a regulated percentage of the fee received which varies with the type of service (e.g. 16% for a consultation in a university hospital, 60% for imaging services).
- The private activity of physicians is regulated as the private activity of any other practitioner. In particular there are two fee regimes, one by which physicians charge the price reimbursed by social security and one in which they can balance bill (called "Sector 2" – for which physicians must receive a specific authorisation).

125. In 2016, 4,722 full-time hospital physicians had private practice contracts (this is around 5% of all employed physicians in public hospitals) and among them, 46% were allowed to balance bill (Assurance Maladie, 2017). Over time, the fees charged by physicians allowed to balance bill have reduced. In 2005, they billed 83% above the regulated fee on average, 62% in 2013 and 45% in 2016, which is probably the result of the concerted effort across the system to reduce "excessive" balance billing.

126. The private practice commission of the Paris public hospital group (APHP) published a report in 2016 which can help illustrate the role of private practice (APHP, 2017). In the group, around 350 physicians (around 6% of those eligible) were engaged in private practice. The median fee billed in 2016 was EUR 82,000, and around 35 physicians billed more than EUR 250,000. The Commission found around 13 cases of irregularities requiring further investigation but also pointed to information system limiting their ability to monitor compliance with the rules.

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Annex D. Israel

Coverage

127. Since 1995, the entire population is covered by the National Health Insurance scheme (NHI) to which contribution payments in form of a progressive pay-roll tax are required. The NHI scheme is implemented by four competing health insurance funds – 'Clalit', 'Maccabi', 'Meuhedet' and 'Leumit'. These funds operate on a not-for-profit basis and the benefit packages they offer under the NHI are standardised and defined by NHI law. In addition to the NHI benefit package, all four insurers also offer Voluntary Health Insurance packages (VHI-HP). These packages are not-for-profit, offered to the entire population (insurance funds cannot decline a client due to prior medical condition) and apply regulated uniform premiums for each age group (no differentiated pricing for pre-existing health conditions). These packages can complement services not included in the NHI benefit package such as dental care, supplement services included in the NHI (e.g. physiotherapy) and give faster access to care and enhance the choice of providers such as the choice of surgeon (duplicate insurance) – however, this coverage can only be used with private providers. In 2014, around 75% of the adult (general) population have this type of voluntary insurance. In addition, there exists a second type of voluntary insurance offered by commercial (for-profit) insurers (VHI-C) frequently as part of private employment benefits. These insurance policies mainly cover services provided by the private health sector. Around 45% of the adult population have this type of voluntary insurance.

128. Consequently, it is not unusual for an Israeli citizen to hold two types of voluntary private health insurance in addition to having coverage under the NHI. Coverage under the VHI-HP is generally perceived (and marketed) as being part of the public service which can explain its popularity although it can only be used with private providers.

Service delivery

129. How service delivery is organised depends on the insurance fund. For primary care, 'Clalit' (52% market share) organises most services in its own clinics with GPs and other staff being salaried employees. Other funds use a mix of contracted independent doctors and their own clinics. For specialist outpatient services, contracting and service delivery – again – depends on the insurer.

Hospitals

130. There are 44 acute care hospitals in Israel. In term of beds, around 47% of acute care hospital beds are in government-owned hospitals, 29% in hospitals owned by the health insurance fund 'Clalit' (both the government-owned and the 'Clalit' hospitals are considered "public hospitals"), 21% in private not-for-profit hospitals, and the remaining hospital beds (3%) are in private for-profit hospitals.

131. Public hospitals are partially financed by their owners, government subsidies, and service provision also paid by the insurance funds by a mix of per-diem and case-based payment. Maximum tariffs are set by the government but insurance funds and hospitals can negotiate discounts. Hospital payments include the costs of physicians and other staff working in a hospital, in addition to equipment, drugs, etc.

132. Government hospitals and 'Clalit' hospitals only provide services under the NHI. They are both barred from providing "private services" since 2002. Services covered by VHI-HP and VHI-C can hence only be provided by private for-profit or not-for-profit hospitals. A number of

these private hospitals are also allowed to provide services under the NHI. Some of the private hospitals that provide services under the NHI, the VHI-HP and VHI-C (like Hadassa, Leniado, Asuta Ashdod) have signed voluntary agreements with the government to limit private activity (by both VHIs), in exchange for governmental funds. One way to limit private activity is by defining a maximum ratio between private and public activity allowed in the hospital (typically, different ratios exist between departments or even specific procedures). Another form of activity limitation is allowing private activity only outside regular working hours.

Employment of physicians

133. In all public hospitals (government and 'Clalit'), physicians are predominantly salaried employees with a fixed work contract stipulating their weekly hours at 42.5 to work for patients receiving care under the NHI package. The terms of employment are negotiated under collective bargaining agreements between the Israeli Medical Association and the employers. Beyond this, physicians have additional work opportunities (for which they need permission by the employer – but which they typically get):

- They can work after-hours in government hospitals and in 'Clalit'-hospitals (to treat patients under the NHI package) for which they will be paid for on a fee-base and the government has recently made additional money available to bring public waiting times down; or
- They can take on additional work in other settings such as private hospitals for which they are paid for on a fee-base by the VHI-C and VHI-HP.

134. For the work mentioned under the first bullet point many government hospitals have established 'trusts' as legal entities to engage physicians after-hours on a fee-basis based on negotiation between trust and the individual physician. The revenues of the trusts stem from the income generated from the provision of surgical and outpatient services under the NHI.

135. Private hospitals in Israel focus on elective procedures and diagnostics and hence have no need for a lot of permanent staff. Most of the physicians working in private hospital have a main job in a public hospital and carry out their private activity in the afternoon or evening after fulfilling their contractual obligation to serve public patients.

136. Generally, the additional income from after-hours work (either in public hospitals or private hospitals) is considered very important for Israeli physicians. A recent study estimates that for doctors employed in government hospitals with more than 10 years of experience the share of private income out of the total salary is around 29% on average but with some variation with income levels (Blinsky et al., 2018). This share has remained relatively stable over the last decade.

137. Alternatively, physicians can work exclusively in the private sector.

Recent developments

138. Debates to limit additional work for employed physicians in the private sector have been ongoing for a long time (BMJ, 1999). Yet, policy makers consider it difficult to limit work outside of the public contracts of physicians since this is perceived as a limitation of the general liberty of the profession.

139. But initiatives to strengthen the public sector and to limit incentives for private practice of doctors are ongoing – mainly triggered by the relative high private health expenditure in Israel

(37% in 2016) and the increase in activity in private for-profit hospitals[21] and resulting concerns about equity and differences in waiting times for treatment between the public and the private sector.

140. Thus, a number of policy measures were introduced in 2016 to address these issues. Firstly, regulations were made to protect patients from being encouraged to get treatment privately. Moreover, when choosing private treatment, patients now no longer need to negotiate the price themselves with the doctor as most doctors are now obliged to work with insurance companies via pre-set contracts. Since these policy moves were expected to increase demand in the public sector, additional financing, amounting to about EUR 200 million was made available to hospitals and the four insurance funds to finance operations in the public sectors, to reduce waiting times, and to invest in essential infrastructure. A further initiative not yet implemented is the so-called "full time initiative" which foresees a significant pay raise for publicly employed physicians in exchange for working additional hours in public hospitals and agreeing not to do additional work in private hospitals.

141. Related to these steps are initiatives to better regulate the VHI-C insurance market to lower premiums. The changes implemented in 2016 include a standardisation of insurance coverage for surgical operations, transparency in price setting, unbundling insurance policies to allow customers to avoid double coverage, and reducing future financial risks for insurance companies, by allowing them to change policies reflecting changes in technology every few years.

142. In the future, additional policies will be examined, such as better monitoring of working times in the public sector, and maximum prices for some procedures.

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[21] Between 2007 and 2011 the number of elective surgeries increased by only 4% in public hospitals but by 58% in private-for-profit hospitals accounting for 36% of all surgery (Rosen et al., 2015).

Annex E. United Kingdom

Coverage

143. Every legal resident in the United Kingdom is covered for services financed by a National Health Service (NHS) funded from general taxation. Around 11% of the population have voluntary health insurance mainly as a duplicate insurance to get broader choice and faster access to private health providers for elective procedures- but they can also use them in Private Patient Units in NHS facilities.

Service delivery

144. Services are provided by a mix of public and private providers. In primary care, provision is predominantly private with private single or group practices providing services for NHS patients for which they are contracted by more than 200 local Clinical Commissioning Groups (CCG) acting as purchasing agents on behalf of the NHS. Outpatient specialist care is predominantly provided in hospitals which are contracted by CCGs to perform this task. Inpatient care in hospitals is mainly provided by public hospitals organised into NHS Trusts or NHS Foundation Trusts. These hospitals may also provide services outside of the NHS. Similarly, independent, non-NHS hospitals may also provide care for NHS patients under particular circumstances.

Hospitals

145. In total, there are roughly 1,900 hospitals in the UK. Most services in public hospitals are now funded based on case-based payment (HRG). There are an estimated 550 private hospitals and 500-600 private clinics providing services that are either not available in the NHS or for which there are long waiting times (Commonwealth Fund, 2017). They generally have no emergency departments or intensive care units. They must be registered with the Care Quality Commission (CQC) and NHS Improvement but can set their own prices for service delivery to private patients. The NHS also purchases services from private hospitals but the volume is still less than 4% of total NHS hospital spending.

Employment of hospital doctors

146. Any NHS professional can engage in private practice, including consultants, GPs, Specialty and Associate Specialists (SAS) doctors and paramedical professions. In all cases, private patient work cannot infringe on the contracted NHS responsibilities of healthcare professionals.

147. In terms of elective private medical treatments, these are conducted by experienced doctors, with relevant professional qualifications. In addition to having relevant professional qualifications, healthcare professionals also must be registered with the relevant professional regulator (e.g. doctors with the General Medical Council and nurses with the Nursing and Midwifery Council). These regulators can take action against a professional who is not fit to practise. As an example, the Association of Anaesthetists of Great Britain and Ireland (AAGBI) state that for anaesthetists the requirements include a medical degree, the award of a medical body fellowship, certification of training and entry into an appropriate specialist register of the General Medical Council (AAGBI, 2008a). Many NHS consultants may also wish to use a team of affiliates such as training grade doctors to assist with private procedures.

148. Even if a doctor is qualified to conduct private practice, consultants must apply to be recognised by private medical insurers, and obtain practice rights from hospitals to perform private treatments in those facilities (BMA, 2016).

149. Any doctor doing private practice will also be required to take out additional medical indemnity insurance for work that will not be covered by the NHS Litigation Authority.

150. Private medical practice in England is regulated by the Care Quality Commission (CQC), with a few exceptions (CQC, 2008). Both NHS and independent sector hospitals are also regulated by the CQC on the safety and effectiveness of the facilities and the services being provided (CQC, 2017).

151. NHS consultants in England are employed under the 2003 consultant contract, which sets out the standard terms and conditions for NHS employees. A full-time consultant is expected to work an equivalent of 10 programmed activities of four hours for each activity. After completing contracted NHS duties, a consultant can engage in private practice, under conditions set out in the terms of employment (NHS Employers, 2018). These terms, along with the 'Code of Conduct for Private Practice' set out a range of conditions which emphasise that private practice should not be carried out to the detriment of NHS patients. They state clearly that in the event of a conflict of interest, NHS commitments must take precedence over private practice. There is no restriction to the amount of additional private work a consultant can undertake outside their agreed job-plan, so long as it does not impact on their obligation to be fit for work (BMA, 2018).

152. In some instances, private practice may take place in NHS facilities. The Code of Conduct for Private Practice states that the NHS facility in which private practice will take place must first authorise the work and any use of NHS staff beforehand, determining and making appropriate charges for the use of services, accommodation and staff. The use of NHS facilities is entirely at the discretion of the organisation.

How much private work is done by NHS staff?

153. The Competition and Markets Authority (CMA) report that most consultants conducting private practice also have NHS responsibilities (CMA, 2014). The CMA reported that of the 37,000 consultants in England in 2012 (NHS and non-NHS), approximately 22,000 engaged in private practice.

154. A study of NHS consultants in 2003/04 found that the ratio of their average private income to NHS income for full-time consultants was 0.26 (Morris et al., 2008). It is important to note as context that under the terms of the pre-2003 consultant contract, full-time NHS consultants were only allowed to earn a maximum of 10% of their NHS income on private practice. More up-to-date data are not readily available; NHS England had planned to make the declaration of private earnings mandatory for NHS staff, but these plans were dropped in 2017 (NHS England, 2017).

155. Market intelligence analysis shows that consultants' private income did not grow by much between 2005 and 2009, having grown strongly from 1995 until 2005 (CMA, 2014).

156. A BMA survey of UK doctors' income found that in 2013, around 45% of doctors engaged in private patient work, compared with 60% in 2005 (BMA, 2013). The survey also showed that a quarter of respondents had an annual private income of less than GBP 10,000. Specialist surgeons and ophthalmologist generally earned the most from private practice.

157. Consultants set their own fees and must be transparent about the cost of fees with patients before treatment is carried out. Bodies such as the AAGBI recommend consultants invoice the patient directly (AAGBI, 2008b). For private practice arranged through insurers, consultants will

Unclassified

claim money directly from insurers (BUPA, 2018). For self-funded clients, the fees will generally be collected from the patient.

Private work in NHS facilities

158. Private practice can be conducted in NHS facilities, as well as through independent sector providers. The structure of private practice in NHS hospitals varies from trust to trust. While some provide a dedicated ward and offer a suite of advertised services, known as NHS Private Patient Units (NHS PPUs) others have no bespoke private patient programme at all and perform private practice on an ad hoc basis.

159. Up until 2012, NHS Foundation Trusts were limited in the amount of income they could raise through private patients to an average of 2%. Under the Health and Social Care Act 2012 this cap was raised to around 49%. Overall, NHS private patient income has been increasing steadily in recent years (CHPI, 2018), but it currently still only represents a small part of total NHS hospital income (<1%).

160. There has been some debate around the expansion of private patient services in NHS hospitals, under the 2012 Health and Social Care Act. While opponents fear that this might pave the way for a two-tiered health system with longer waiting times for public patients, others argue that the provision of private services in NHS hospitals would meet a public need and that this could be organised without being detrimental to NHS patients (BMJ, 2012; BMJ, 2013). At any rate, the proportion of private patients in all patients treated in NHS hospitals has remained small and unchanged since the regulatory change (BMJ, 2018).

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