Value for Money and Policy Review of the Economic Cost and Charges Associated with Private and Semi-Private Treatment Services in Public Hospitals

CONSULTATION DOCUMENT

<u>Part 1. Purpose of this Consultation</u>

The Department of Health and Children is currently undertaking a Value for Money and Policy Review of the Economic Cost and Charges Associated with Private and Semi-Private Treatment Services in Public Hospitals. A key element of the Review is a consultation process which aims to elicit the views of stakeholders.

The purpose of the consultation process is as follows:

- To communicate the aims and terms of reference of the Review to the stakeholders.
- To provide an opportunity to a broad range of stakeholders to participate in the Review and put forward their views in relation to the economic cost and charges associated with private and semi-private treatment in public hospitals and the processes involved in recouping the fees for same from private insurance companies.
- To have regard to the views of stakeholders and to inform the review recommendations.

Structure of Consultation Document

The questionnaire element of the consultation document is split into five distinct areas as follows:

A. Respondent Information;

B. Methodological Issues in Establishing the **<u>Cost</u>** of Treatment Services for Private and Semi-Private Patients in Public Hospitals;

C. Policy Issues related to the **<u>Charging</u>** for Private and Semi-Private Treatment Services in Public Hospitals;

D. Collection of Fees from the Private Health Insurance Companies; and

E. Other Issues.

A brief outline of some of the key issues involved with parts B (the cost of treatment services) C (charges for treatment services) and D (collection of fees) is provided to assist you in completing the document.

Notices to Respondents

- All questions/queries must be submitted in writing (by e-mail) to Mr. Robert Deegan (VFM_Review@health.irlgov.ie).

- Submissions should be made no later than **17:00 on Friday 04 September 2009.** Unfortunately, late submissions cannot be accepted. Email responses should be sent to VFM_Review@health.irlgov.ie while postal responses should be sent to:

  Review of the Economic Cost and Charges Associated with Private and Semi-Private Treatment Services in Public Hospitals,
  Performance Evaluation Unit,
  Room 11.16,
  Department of Health and Children,
  Hawkins House,
  Dublin 2.

- Freedom of Information: The Department of Health & Children undertakes to use its best endeavours to hold confidential any information provided by you in

response to this questionnaire, subject to the Department of Health & Children's obligations under law, including the Freedom of Information Acts, 1997 to 2003. If you believe that any of the information supplied by you should not be disclosed because of its commercial sensitivity, you should identify this information and state the reason for its sensitivity. The Department of Health & Children will consult with you about this sensitive information before making a decision on any Freedom of Information request received.

Part 2. Background to the Review

The purpose of the review is to carry out a detailed analysis of the costs and charges associated with providing private and semi-private treatment services in public hospitals and investigate the fee collection processes used to recoup the cost of these services from private health insurance companies. Appropriate recommendations will be formulated in each of the areas of cost, charge and fee collection.

The study reflects the fact that, following significant increases in the per diem charge for private accommodation in recent years, more precise information and charging mechanisms will be required in moving closer to full economic charging for private treatment in public hospitals. An analysis of the fee collection process is required in order to address the significant problem of delays between the discharge of private patients and the recoupment of fees from the private health insurance companies.

The Review is being conducted in line with practices and guidelines currently prescribed by the Department of Finance and in accordance with the Government decision in relation to the 2009-2011 round of the Value for Money & Policy Review Initiative. This Initiative is part of a framework introduced to secure improved value for money from public expenditure. The objectives of the Initiative are to analyse Exchequer spending in a systematic manner and to provide a basis on which more informed decisions can be made on priorities within and between programmes.

Terms of Reference

The Review will identify the objectives underpinning the economic charging for treatment services, and examine the extent to which, and the effectiveness with which, this has been achieved as follows:

(a) Assess the economic cost of providing services to private and semi-private patients in public hospitals;
(b) Compare the economic cost with the current charge;
(c) Examine the processes in place to collect fees in respect of private and semi-private patients in public hospitals;
(d) Make recommendations on the costing of, and charging for, private and semi-private patients in public hospitals and on the collection of fees for same, having regard to consultations on the matter;
(e) Specify performance indicators to measure the implementation of the recommendations.

Membership of the Steering Group

The review will be overseen by a Steering Group, chaired by an independent Chairperson, and comprising officials from the Department of Health and Children, the Department of Finance, and the HSE. The full list of members is shown below.

Name	Role
Mr. Tom Ferris	Chairperson
Mr. Jim Breslin, Assistant Secretary, Finance, Performance Evaluation, Information & Research, DoHC (Department of Health and Children)	SG Member
Ms. Tracey Conroy, Principal Officer, Performance Evaluation Unit, DoHC	SG Member
Mr. Tony Flynn, Assistant Principal Officer, Performance Evaluation Unit, DoHC	SG Member
Mr Dermot Smyth, Assistant Secretary, Resource Allocation Review Unit/Eligibility Review Team/Public Private Policy Issues and Health Insurance, DoHC	SG Member
Mr. Fergal Goodman, Principal Officer, Acute Hospitals Division, DoHC	SG Member
Mr. David Smith, Principal Officer, Finance Unit, DoHC	SG Member
Ms. Patricia Purtill, Principal Officer, Sectoral Policy Unit, DoF (Department of Finance)	SG Member
Mr. Cormac Gilhooly, Principal Officer, Central Expenditure Evaluation Unit, DoF	SG Member
Mr. Eoin Dormer, Assistant Principal Officer, Central Expenditure Evaluation Unit, DoF	Report Co-author
Mr. Brian Donovan, Casemix/HIPE Unit, HSE (Health Service Executive)	SG Member
Ms. Yvonne O'Neill, Assistant National Director, HSE Value for Money Directorate	SG Member
Ms Fionnuala Duffy, National Hospitals Office, HSE	SG Member
Mr. Robert Deegan, Performance Evaluation Unit, DoHC	Lead Reviewer

Delivery Dates

It is anticipated that an interim report encompassing an analysis of the costs associated with private beds in public hospitals as well as recommendations on the charges for 2010 will be delivered in September 2009. The final report with a more detailed examination of the costs and charges as well as an evaluation of the processes in place to collect charges from private health insurance companies will be completed by end December 2009.

Part 3. Issues for Consultation

A. Respondent Information

A1. Name: _George McNeice_

A2. Are you responding on behalf of an organisation?

Yes_X_ No__

A3. If yes, please give the name of the organisation and your role:
Chief Executive
Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2

B. Methodological Issues in Establishing the Cost of Treatment Services for Private and Semi-Private Patients in Public Hospitals

In calculating the cost, the Department predominantly relies on cost and activity information sourced from the National Casemix System.

The Casemix Budget Models form part of the annual funding process for 39 of the largest hospitals in the country (accounting for over 90% of national activity) and essentially involves the redistribution of funding between hospitals based on their relative efficiencies. The "matching" of costs with activity is the underlying principal governing Casemix. Thus the review and audit of both costing and activity data are essential components of the Casemix system.

The cost per inpatient bedday for each hospital is calculated from the data used within the Casemix system. The starting point in the Casemix Costing process is the Annual Financial Statements (AFS) of the hospital. This is to ensure that the costs to be used by the hospital will be subject to audit, in most cases by the Comptroller & Auditor General.

The inpatient and daycase activity data is recorded on the national hospital collection system called HIPE (Hospital In-Patient Enquiry). Every patient collected on this system is coded and classified into DRGs (Diagnosis Related Groups) based on their diagnosis and the procedures carried out while they are in the hospital. The beddays relating to these cases is used in the calculation of the cost per bedday.

As part of the Costing process, there is an Instruction Manual to cater for the completion of the Costing return for use in the Casemix Model. The purpose of this manual is to ensure the Costing returns are prepared on a consistent basis from year to year and from hospital to hospital. The manual sets out the rules for preparing the costing returns in relation to costs apportionments and allocations.

All costing returns are reviewed in detail by the Casemix Costing Unit and the Costing returns of a number of hospitals are audited each year. The Casemix Costing

section maintains and updates the reporting system used by the hospitals in their submissions to the HSE. The same process applies for the calculation of cost per daycase.

How the Economic Cost is Estimated

The estimate of an "economic cost" of a private patient in a public hospital is currently calculated using an average cost per bedday for each hospital category based on the hospitals in that category. The cost per inpatient bedday is a full cost containing all costs in relation to the treatment of inpatients and would include the following:

- All Pay costs e.g. Medical(Consultant and Non-Consultant Hospital Doctors), Nursing, Paramedical, Administration, Support Services, Catering, Portering.
- All Non Pay costs e.g. Medicines, Blood, Medical & Surgical Supplies, Radiology, Laboratory supplies etc.
- Costs of Diagnostics, Medical Services, Theatres, Laboratories, Wards and Overhead allocations as appropriate.

The following costs are excluded from the cost per bedday:

- Superannuation
- Non Capital expenditure on Capital items
- Bad Debts
- Retail Outlets Costs
- Exceptional Costs
- Costs not related to a hospital's patients.
- Other Unique Issues as agreed with the Casemix Unit
- Outpatient Costs

The cost per bedday as calculated for the Casemix Budget Models is then adjusted as follows:

- Consultants pay is excluded as they are paid separately by the Insurer
- The cost per bedday is increased by annualised health inflation rates to synchronise the cost per bedday with the relevant charge. e.g. 2007 cost per bedday was inflated by 20% to compare with 2009 private charge.

The private and semi private charges for each category, which are daily rates, are then set after taking into account the cost per bedday within each category as calculated above.

B1. How satisfied are you that the current method of establishing private and semi-private patient treatment **costs** in public hospitals is appropriate?

Very satisfied ___
Satisfied ___
Neither satisfied nor dissatisfied ___
Dissatisfied ___
Very dissatisfied _X_

B2. Please give reasons for your answer:

The current method of establishing private and semi-private patient treatment charges is based on average per diem costs, yet treatments received by patients in hospital can vary in cost enormously. While this method is administratively simple and therefore inexpensive to operate, it lacks transparency. Patients and tax-payers are unable to tell if they are receiving real value for money.
By excluding the full economic cost of treating private and semi-private patients in public hospitals, tax-payers are effectively subsidising costs to private health insurance companies. Private health insurance companies reimburse private hospitals on the full cost of care, including disposables. The IMO believe that public hospitals should charge and be reimbursed on the same basis as private hospitals.

B3. In your view, should capital costs be reflected in calculating the economic cost?
Yes _X_ No__ Don't know__

B4 If you answered yes, please specify how you would see this being done:

The IMO's understanding is that capital costs – diagnostics, theatres, laboratories, wards – are already included in the economic cost. The IMO believe all capital costs including non-capital expenditure on capital items should be included in the economic cost. Charges should be based on actual costs.

B5. Are there other costs which should be **included** in the calculation?

Yes X_ No__ Don't know__

B6. Please give reasons for your answer:

Provided there are no other changes to policy and legislation the IMO believe charges could be increased to reflect all hospital related costs. However measures should be implemented to guarantee that all patients (both public and private) receive value for money in clinical care and that administrative and non front-line costs are kept to a minimum.

B7. Are there other costs which should be **excluded** from the calculation

Yes__ No__ Don't know__

B8. Please give reasons for your answer:

____
____
____
____

C. Policy Issues related to the Charging for Private and Semi-Private Patients in Public Hospitals

On admittance to hospital, current rules stipulate that patients must make a clear choice between fully private and fully public status, in respect of both consultant and accommodation. Historically, private and semi-private accommodation in public hospitals has been subsidised by the Exchequer. However, since the publication of the White Paper on Private Health Insurance in 1999, Government policy has been to move towards charging the full economic costs for the use of such facilities, while being sensitive to the need for continuing stability in the private health insurance market. This policy has seen significant increases in private charges in recent years.

The level of charge applicable to private in-patients and day patients does not vary from hospital to hospital. Instead the charge is set in accordance with the category of hospital the service is provided in, whether private or semi-private accommodation is being used and the length of the stay. This approach to charging is referred to as "per diem charging". The different rates applied to the three categories of hospitals are primarily intended to reflect the fact that there are varying levels of costs between major tertiary and teaching hospitals and general hospitals. Day care charges are set as a percentage of the overnight applicable to the particular hospital.

The charges in respect of private and semi-private accommodation in public hospitals applicable from 1 January 2009 are set out in the table below:

	Hospital Category	**Private Accommodation**	**Semi-Private Accommodation**	**Day-care**
1	HSE Regional Hospitals, Voluntary & Joint Board Teaching Hospitals	€910	€713	€655
2	HSE County Hospitals Voluntary Non-Teaching Hospitals	€607	€488	€434
3	HSE District Hospitals	€260	€222	€193

These charges are in addition to the public hospital statutory in-patient charge which currently stands at €75 in respect of each day during which a person is maintained. The maximum payment in respect of the statutory charge in any twelve consecutive months is €750. It should be noted that these charges are not inclusive of the consultant costs which are paid directly from the private health insurers to the consultants.

The issue of charging for private facilities in public hospitals was addressed in the recent Report of the Special Group on Public Service Numbers and Expenditure Programmes. The Group recommended that the charge for private facilities in public hospitals be increased by 20% to reflect economic costs and this should generate estimated Exchequer savings of €50m.

Examples of possible alternatives to the current average per diem approach include disease specific per diem charge, charging by case-mix group or charging based on patient level costings among others. Disease specific per diem charging involves categorising diseases and establishing a daily charge for treatment of each category. Charging by case-mix group involves establishing a price for each category of case or patient and takes into account the length of stay. Patient level charging involves identifying a charge for each element of the treatment services received by individual patients. This list of possible approaches is not exhaustive and other alternatives could be applied.

A system of bed designation is operated in order to control the level of private activity in publicly-funded hospitals and to help ensure equitable access for public patients to services in these facilities. This system, formally implemented by the Health Services (In-Patient) Regulations 1991, designates approximately 20% of the total beds in acute hospitals as "private". The majority of the remainder of the beds are designated as "public" with approximately 6% classified as "non-designated". The non-designated beds are open to both public and private patients and are comprised of intensive care and other specialist beds. This affects hospital revenues because private patients accommodated in public beds and non-designated beds are not liable for a private bed charge.

C1. In your view is the current categorisation of hospitals an appropriate basis for applying **charges**?

Yes__ No X Don't know__

C2. Please give reasons for your answer:

The current application of charges, based on average per diem cost per hospital category, lacks transparency. As mentioned above, while it is simple and inexpensive to administer, patients have no way of knowing if they are receiving real value for money. Patients can pay higher charges for the same treatment and outcome in a Category 1 hospital as in a Category 2 hospital.

In health systems with spare capacity, per diem charges can also encourage admissions and longer lengths of stay.

Private health insurance companies reimburse private hospitals on the full cost of care, including disposables. The IMO believe that public hospitals should charge and be reimbursed on the same basis as private hospitals.

C3. What approach would you MOST favour in terms of charging?

- Continue with current regime (i.e. average per diem) ____
- Disease specific per diem charging ____
- Charging by Casemix group ____

- Patient level charging ____
- Other (please give details) ___________________________X_

C4. Please give reasons for your answer:

No change to the current approach to charging should be made until a thorough evaluation of all the models is carried out. The IMO believe that the timeframe for reporting on the Review of the Economic Cost and Charges Associated with Private and Semi-Private Treatment Services in Public Hospitals is inadequate to carry out an assessment of any relevance.
All approaches to charging for healthcare have their advantages and disadvantages. A recent review of Healthcare Payment Systems by PricewaterhouseCooper's Health Research Institute[1] found that that while case-based prospective payment systems have proved to be the emerging norm for hospital payment, two-thirds of those surveyed thought their payment methods would change in the future. Some of the difficulties with current payment models are:

- Many models, particularly case-based models, are unable to capture the multiplicity and complexity of illnesses related to an ageing population;
- Payment systems are not structured to support future delivery models - that is the transfer of many secondary services into a primary care setting;
- Payment systems focus on cost control rather than quality and efficiency and lack the flexibility to cope with rapid changes in new technology and treatments.

The IMO also believe that the payment model is not independent of the provider model or the insurance model. Careful consideration should be given to the profit or non-profit basis of hospitals and insurance companies in other systems. For example - in the US the combination of a case-based payment model, with for-profit hospitals and health insurance companies has led to increased admissions for certain case mixes and early discharges for others.

C5. If your preference is for an approach different to the current per diem mechanism, please briefly outline how you would see that approach working in practice.

In addition to a thorough evaluation of current payment models, a careful assessment of how a chosen model might work in practice must also be carried out. Again, the IMO believe the timeframe for reporting is inadequate to carry this out.

C6. Please identify the main implications of charging the full economic cost of private and semi-private patient treatment in public hospitals to:

(a) you/your organisation/your members/users of the health system?

Provided there are no other changes to health policy and legislation, charging the full economic cost of private and semi-private patient treatment in public hospitals will

[1] PricewaterhouseCooper's Health Research Institute, You Get What You Pay For – A Global Look at Balancing Demand, Quality, and Efficiency in Healthcare Payment Reform 2008

have little impact on IMO members and users of the health system as it will have little effect on demand on the State's already overstretched public hospital system.

(b) the private health insurance market?

Over the past decade increases in charges for private and semi-private patient in treatment in public hospitals has had little effect on the demand for private health insurance.
In the current economic climate, the numbers of people covered by private health insurance has begun to drop. 13,000 people dropped private health insurance in the first quarter of 2009. An increase in premiums will lead to a further gradual reduction in the number of people purchasing private insurance. However, the principal factor driving demand for private health insurance is still delays in the public system – waiting times in A&E and for access to diagnostics and treatments.

(c) the private health care market?

While an increase in charges would appear to put public hospitals in direct competition with private hospitals for the treatment of private patients, the reality is that private hospitals, in order to make profit, tend to select patients for low cost elective care, while public hospitals continue to provide the full range of cost intensive, emergency, complex or chronic care. GPs instinctively perform a type of triage, referring very ill patients to public hospitals where a more complex range of emergency services are available. Private hospitals transfer certain emergency patients to larger public hospitals for intensive care or dialysis etc. And many public patients with expensive complex conditions that have been referred to the National Treatment Purchase Fund (NTPF) for treatment in the private sector have their files returned with unsuitable for NTPF.
Unless a model for charging patients is introduced which more accurately reflects the level of treatment, an increase in charges will see patients requiring low-cost interventions further pushed towards the private sector where the cost base is lower while those requiring expensive care will continue to be treated in public hospitals, where they are just charged an average per diem rate.

(d) the wider health care system?

As mentioned above, provided there are no other policy and legislative changes, an increase in charges is unlikely to affect demand on the State's already overstretched public hospital system.
There is currently a shortage of acute public hospital beds, which mainly affects public patients awaiting elective surgery and both public and private patients requiring specialist treatment for complex chronic diseases. Current plans to increase acute bed capacity through the co-location of private for-profit hospitals on public hospital sites is unlikely to address the issue. The public hospitals system will continue to act as a safety net for the private system both clinically and financially by taking on both the sickest and the more expensive patients.
Furthermore, any revenue increase created by charging the full economic cost is likely to be negated by the co-location project, which will ultimately lead to a substantial loss of revenue (estimated at €100m) to the public system.

The IMO believe that while there is a place for private medicine in Ireland, it must not be at the expense of public patients. Access to hospital services must be based on medical need and not on ability to pay. The IMO calls on the Government to immediately put a halt to the co-location project and recommends that revenue raised from increased charges to private and semi-private patients is used to fund units for elective patients and patients with chronic illness.

C7. In your view, do the current levels of charge represent value for money for the taxpayer?

Yes__ No _X Don't know__

C8. Please give reasons for your answer:

As mentioned above the current level of charging means that the tax-payer effectively subsidises costs to private insurance companies.
The IMO would also like to point out that the model for charging contributes only marginally to perceived value for money. Real value for money in healthcare is based on transparency, prompt access to diagnostics and treatment, quality of care, evidence-based clinical practice and efficiencies in administration and other non-frontline services.

C9. Do you agree with the recommendation of the Special Group on Public Service Numbers and Expenditure Programmes to increase the charge for private facilities in public hospitals by 20% to reflect economic costs?

Yes_X_ No ___ Don't know__

C10. Please give reasons for your answer:

The IMO believe that provided there is no change to healthcare policy and legislation charges for private facilities in public hospitals could be increased by 20% to reflect economic costs.
The Group has proposed a 20% increase for the sole purpose of raising extra revenue. As mentioned above, the loss of patients toward the private sector combined with the current co-location project is likely to negate any increase in revenue raised by this recommendation. An estimated €100m is likely to be lost through the co-location project alone.

C11. How satisfied are you with the current system of bed designation which operates in public hospitals.

Very satisfied ___
Satisfied ___
Neither satisfied nor dissatisfied ___
Dissatisfied ___
Very dissatisfied _X_

C12. Please give reasons for your answer:

The current system, designates 80% beds to public patients and 20% to private patients, yet 50% of the population purchase private health insurance. The IMO believe that all public beds should be designated to patients based on medical need and not on ability to pay.

C13. Are there other issues which you believe need to be taken into consideration in relation to setting the level of charges? Please be specific in your answer.

The IMO warns against the consequences of following the American model of healthcare where total healthcare expenditure accounts for over 15% of GDP. The statutory right to hospital care in Ireland must remain in place or, as in the US, those not covered by private health insurance could be left bankrupt by healthcare charges. While we may believe that we are following the European model of healthcare, it is important to remember that in European countries the majority of hospitals and health insurance companies are run on a voluntary not-for-profit basis.

D. Collection of Fees from the Private Health Insurance Companies

The amount recouped from private health insurance companies by the HSE and voluntary hospitals in relation to private accommodation in public hospitals is significant. However, the evidence suggests that there is a considerable amount outstanding and that there can be lengthy delays between the discharge of patients and the receipt of payment from the health insurance companies.

This issue was examined by the Special Group on Public Service Numbers and Expenditure Programmes. The Group recommended that the HSE should accelerate significantly the levels and timeliness of hospital charge income, improve collection arrangements and set a target to reduce arrears to no more than €50m by end 2011.

D1. In your view, are there barriers which inhibit the prompt recoupment of charges for private and semi-private treatment in public hospitals **on the side of the hospitals/HSE?** (We are interested in the views of all parties)

Yes__ No__ Don't know__

D2. If you answered yes, please identify the barriers:

______No comment ____

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D3. Are there measures which could be taken by the **hospitals/HSE** to speed up the recoupment of fees for private and semi-private treatment in public hospitals from private health insurance companies?

Yes__ No__ Don't know__

D4. Please give reasons for your answer:

No comment

D5. In your view, are there barriers which inhibit the prompt recoupment of charges for private and semi-private treatment in public hospitals **on the side of the Health Insurance Companies?** (We are interested in the views of all parties)

Yes__ No__ Don't know__

D6. If you answered yes, please identify the barriers:

No comment

D7. Are there measures which could be taken by the **Health Insurance Companies** to speed up the recoupment of fees for private and semi-private treatment in public hospitals from private health insurance companies?

Yes__ No__ Don't know__

D8. Please give reasons for your answer:

No Comment

E. Other Issues

E1. If there are other issues which you feel are relevant to the review but are not covered in the questions above, please include them below.

The Steering Group is particularly interested in any data, analysis or evidence which you can provide to support your submission. Please email any such material to VFM_Review@health.irlgov.ie

Thank you for participating in the consultation process