25th April 2016

“Six proposals to improve patient outcomes through collaboration between private hospitals and the public health care system in Ireland”

Summary

The Private Hospitals Association has published 6 proposals which it believes will bring significant, positive, outcomes for patients, support the public health system and ease some of the pressures it is facing in the coming years.

Every year, the association of 19 hospitals providing acute medical and mental health services, makes over 1 million bed nights available, treats 400,000 patients, carries out over 250,000 procedures and completes 3 million diagnostic tests. PHA members undertake around 50% of all heart surgeries and 65% of all spinal surgeries carried out every year and provide one in ten inpatient psychiatric beds in Ireland.

The Association today set out six steps which the incoming Minister for Health should take:

1. Design a joint public and private sector initiative to tackle waiting lists for both inpatient and outpatient treatments including a focus on diagnostics;
2. Move patients more quickly through Emergency Departments by using all available beds in both the public and private sectors;
3. Address the gaps delaying patient treatment by launching a coordinated approach to attracting consultants and other health professionals to work in Ireland;
4. Introduce a new competitive system for commissioning hospital care by 2018;
5. Coordinate planned investment in medical facilities and equipment to avoid duplication, get value and create efficiencies;
6. Establish a task force to boost co-operation between public and private healthcare systems.
Introduction and context

Anticipating the formation of a new Government in Ireland in the spring of 2016, at a time of escalating pressure on the public health system, the Private Hospitals Association (PHA) believes it is timely to make an input into the debate and offer some proposals as to how private healthcare providers can assist in tackling the increasing waiting lists in the short term and addressing some of the underlying challenges in the health system in the longer term.

PHA members bring considerable expertise and experience to this discussion. Our members run almost one third of the acute hospitals in Ireland. Our hospitals provide over 1 million bed nights per annum including 10% of inpatient psychiatric beds. Our 19 hospitals undertake at least 50% of elective procedures performed in Ireland and employ over 8,000 staff including over 5,000 nurses. In broad terms, we deliver approximately one fifth of acute hospital care provided in Ireland each year.

There is a growing public consensus that planning healthcare reform in Ireland requires a long term perspective (much longer than a single 5-year Government term). The PHA shares this view, endorses the consensus that a cross party approach should be developed in the Oireachtas and looks forward to contributing actively to that policy discussion over the life time of the new Dáil. Urgent solutions to the challenge of expanding waiting lists are, however required in the immediate future. Therefore, we are setting out in this document six proposals which we believe will accelerate the treatment of patients during 2016 as well as proposing some steps that will bring longer term benefits.

The principle underlying our proposals is that we should work together to make the best use of healthcare resources available in the country (hospital beds, operating theatres, medical professionals, diagnostic equipment, mental health expertise…) as effectively as possible. The PHA believes that a closer dialogue involving the Department of Health, HSE and all hospitals (regardless of ownership) could do much to optimise use of these resources through better, more predictable planning, creative approaches to sharing human and physical resources and wise investment decisions etc.

The extent to which the Government is constrained in terms of capital as well as current investment in health in the coming years accentuates the problem. For a variety of reasons, the construction of new hospital facilities involves very long planning and development timelines.

As Irish demographics change and our citizens enjoy increasingly lengthy lives, the priorities of health care are shifting with an increasing focus on the management of chronic conditions and a need for new approaches to care delivery which has implications for the public health system, primary care providers, as well as private hospitals and indeed the private health insurers. Over the coming years the PHA looks forward to participating in the planning to address these trends.
The 6 proposals

Proposal 1 – Design a structured “Waiting List Capacity Initiative” to run for next 5 years.

There is an opportunity to significantly reduce the risks arising to patients on waiting lists in Ireland. Figures to end March 2016 show that both in patient and out patient waiting lists are rising at an accelerated rate in comparison to 2015. The total number has now reached 500,000 with particularly worrying increases in the proportion of patients waiting more than 12 months. (Almost 10,000 people are now waiting more than 12 months for inpatient treatment.) The pressure on Emergency Departments in the public system and the consequent escalation policies have led, for understandable reasons, to the cancellation of a significant number of elective procedures in major hospitals over recent months.

In order to tackle the scale of the waiting lists and, in particular the number of patients that are waiting more than 12 months for their procedure, the Government should move quickly to develop a structured “Waiting List Capacity Initiative”.

During 2015, on a once off basis the HSE ran a successful process to procure treatment for some of the patients waiting longest on public lists which meant that many thousands of patients were swiftly treated in private hospitals.

As it is clear that elective waiting lists will continue to be a problem for forthcoming years it is now the time to design a structured, multi-annual waiting list initiative. By learning from last year’s experience and drawing on the best aspects of the National Treatment Purchase Fund scheme that ran from 2003 until its suspension in 2011, there is an opportunity to design a scheme that prioritise those patients most in need, on waiting lists and to provide very good value for money to the exchequer.

Private hospitals, can offer best value to Government in delivering such a scheme if:
   a) It is the subject of consultation before commencement
   b) it is predictable
   c) it is designed to run for several years
   d) it can be phased during each year so as to fit with peaks and troughs in other demands for hospital services

Private hospitals are very effective in planning the use of resources such as operating theatres and diagnostic equipment and in the rostering of staff so as to respond to additional demand for services. Therefore, the more certainty there is at an early date about the design of such a scheme and the process of procurement as well as the details of implementation, the better value for money the exchequer will obtain.

1 NTPF figures March 2016
Given the scale of the waiting list challenge and the constraints on capital investment facing the Government, it would be advisable to plan a scheme that would run for the next 5 years.

**Diagnostic tests – a specific priority**

An important part of the initiative should be to tackle the unnecessary delays in diagnostic procedures. Once public patients have been seen by their GP or a hospital doctor, a backlog often arises while they queue for relatively inexpensive diagnostic tests such as MRI scans and endoscopies because there are not enough specialist staff in the public system to cope with the demand. For example, at the end of March 2016 over 8,000 patients had been waiting on a list for more than 3 months (the targeted maximum waiting time) for a GI endoscopy and half of them had been waiting more than 6 months for this day procedure.

There ought to be no reason why any patient in Ireland should have to wait more than 13 weeks for a diagnostic test such as an MRI or endoscopy given the investment that has been made in the necessary equipment in recent years by private hospitals and the HSE.

There is a high level of capacity to undertake diagnostics in the private sector. PHA members would be happy to explore an arrangement whereby cohorts of patients on public waiting lists could undergo these procedures as day patients in private hospitals. The speedy undertaking of such diagnostic procedures is of considerable benefit in identifying those patients who need further treatment as a priority and those which can be given reassurance that their condition is not serious. The early identification of a serious issue clearly has benefits in terms of reduction in cost and complexity of treatment. The early identification that there is no cause for concern clearly has benefits in terms of peace of mind.

**Proposal 2 – Provide more capacity for patients by taking a joined-up approach to allocating beds across the entire network of hospitals.**

Given the overall pressure on accommodation in public hospitals, as evidenced by the levels of Emergency Department overcrowding in winter 2015/2016, a review of the policy with respect to utilisation of beds in the entire system is warranted.

It might be noted that the relatively recent investment by private hospitals in emergency departments and medical assessment units has meant that A&E pressure is not even greater. In Dublin alone, approximately 30,000 patients use private Emergency Departments in every year. This equates to the patient levels of an A&E in a large public hospital. As a result, the private sector complements the capital’s emergency medicine services and relieves some pressure from the system.
Every effort should be made to ensure the optimal allocation of all available beds in the system when assessing patients presenting at Emergency Departments. When a hospital is facing potential overcrowding, one of the first questions a bed manager should be asking themselves when considering the admission of a patient is “Could this patient be treated equally well in a private hospital thereby freeing up a bed for another patient here?”.

There will be occasions where it is more appropriate for the patient to be treated in the public hospital where they present (e.g. due to the urgency of their needs or the specific condition requiring treatment). On other occasions, however, a bed might be allocated in a nearby private hospital. This would mean beds being found for two patients instead of just one.

This approach would require close cooperation between both managers and clinicians in the public and private systems to ensure that patient safety is assured. For 2016 we would recommend the development of pilot projects involving neighbouring public and private hospitals in two or three areas of the country to explore how such an initiative could work most effectively.

Proposal 3 - Government and Private Hospitals should work together to attract medical consultants, nurses and other health professionals to come (home) to Ireland

Many delays in patient treatment in Ireland stem from the shortage of medical professionals. The challenge of recruiting sufficient suitable professionals (Consultants, NCHDs, nurses and allied professions) to work in our health system is one that is shared by both the public and private systems. We are all competing in a global market to attract, attract back and retain health professionals.

We recommend the establishment of a joint task force to develop a national strategy for international healthcare recruitment. This group should involve a wide range of actors including Government, HSE, voluntary hospitals, the Medical Council, Nursing & Midwifery Board, and CORU, the relevant professional Colleges as well as private hospital representatives.

By working together, we can best showcase the range of employment opportunities available in the health sector in Ireland, identify and tackle blockages to recruitment and develop employment offerings that will make Ireland attractive to professionals with the level of expertise which we would hope to attract.

In particular, there is potential to take a unified approach to attracting Consultants to come (home) to work in Ireland by offering professional opportunities spanning both the public and private system. Many Doctors welcome the opportunity to practice in more than one hospital so as to broaden their skills.
Proposal 4 - Prepare to allow all hospitals offer to deliver treatment by 2018

In the medium term, the way to ensure patients are treated as effectively as possible is for the Government to move to a new way to commission treatment from hospitals. The Department of Health is currently beginning to implement a system intended to distribute state funding to hospitals in return for care provided rather than on the historical basis of block grants.

It will also provide the State – through a new Healthcare Commissioning Office, with the capacity to assess which hospitals offer the best value for money for the delivery of any particular services that are required.

The time has now come for the Department of Health to begin to engage with private hospitals about how this system will work in practice and to set a target date at which private hospitals will be invited to become involved. We would recommend that this process should be in place for the delivery of care, including mental health care during 2018.

Proposal 5 – Develop a joined up approach to Capital Investment in health care in Ireland

In order to offer patients the best quality and most innovative treatments, both public and private hospitals in Ireland make substantial capital investments in new equipment and facilities every year. PHA members invest several tens of millions of Euro annually in new equipment and improved medical facilities.

Despite patient need, in some cases, no hospital in either the public or private system will, on their own, treat enough patients annually to justify investment in a particular specialist service. In such circumstances in makes good economic sense to explore the scope for one hospital making the investment and contracting to make the service available to neighbouring hospitals.

Similarly, it makes sense to avoid two hospitals in the same area investing in identical additional facilities and equipment which are then under-utilised.

In order to avoid this happening a “Capital Investment Clearing Desk” mechanism should be established which will facilitate both public and private hospitals signalling their investment plans, identifying other hospitals interested in such projects and avoiding wasteful overlapping investments.

Proposal 6 – Minister for Health should establish a Taskforce to encourage exchange and dialogue between public and private healthcare systems
New developments in treatment, patient safety, and technologies constantly emerge in healthcare leading to better patient outcomes. There should be a constant process of exchange between all hospitals in the Irish system so as to ensure that these benefits are available to all patients. As noted earlier in this document private hospitals account for a significant proportion of hospital care delivered in Ireland. There is considerable exchange at an operational level between the public and private systems. Many doctors, nurses and other health care professionals work in both systems at different times in their careers. Many patients are also cared for in both systems at different times. Yet, there is very little formal dialogue between the two systems.

There are a range of issues where structured dialogue between health policy makers and private hospitals would bring benefits to patients. The rollout of E-health policy, medical manpower strategy, capital investment planning, procurement, patient safety and quality, healthcare governance, innovation, and connected care are some examples.

While in some areas, such as patient safety, there are reasonably well developed mechanisms for co-operation, in others areas this is not the case.

We would recommend that the newly appointed Minister for Health should establish an independently chaired review to explore the scope for better dialogue and exchange between the systems. Such a review to be concluded by end of 2016 with a view to establishing a permanent task force or other arrangement to facilitate ongoing exchange.

Ends