

Public and private patients in Public hospitals

Guidance to health service management on the treatment of public and private patients

16th September 2009

Purpose of guidance

This guidance sets out revised arrangements for the processing and treatment of public and private patients arising from instructions issued by the National Director, National Hospitals Office, Health Service Executive (HSE) and the Department of Health and Children (DoHC). It reflects changes to the interpretation of eligibility legislation and the introduction and enforcement of Consultant Contract 2008.

These arrangements set out to ensure that persons attending public hospitals have access to services on an equitable basis – irrespective of whether they attend as public or private patients.

Please review procedures in your hospital and make any changes necessary to comply with these arrangements.

This guidance builds on and incorporates elements of a range of documentation relating to processing and treatment of public and private patients issued over the past two years. A list of relevant documents is included at Section 12.

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1. Common protocols applying to public and private patients

Common protocols are to be applied to the management of public and private patients referred for outpatient diagnostics or treatment.

Should referrals from General Practitioners be permitted, such referrals must include both public and private patients without differentiation relating to public or private status.

2. Attendances at public and private clinics

Persons referred to Outpatients must be treated as public patients unless they are clearly identified as private on the initial referral documentation. If they are identified as private patients and wish to be treated privately, they must be referred to an appropriate private outpatient clinic.

No private patients may be called to public outpatient clinics.

Patients attending public Outpatient / Emergency Departments must never be asked whether they have private insurance or wish to be treated privately – for any reason.

Consultant Contract 2008 explicitly requires that Consultants do not charge private fees in respect of patients attending Emergency Departments in public hospitals or patients attending Public Outpatient Services in public hospitals. This includes Consultants performing diagnostic investigations or treatment on patients referred from public Outpatient / Emergency Departments.

3. Common Waiting List for Outpatient Diagnostics and Treatment

All patients – public or private – requiring diagnostic or treatment procedures following an outpatient consultation must be placed on a Common Waiting List if there is a waiting period for access to the procedure.

A Common Waiting List is one which includes all patients – irrespective of public or private status – awaiting a particular procedure.

Patients must be called from Common Waiting Lists regardless of public or private status:

- i) in order of clinical priority, followed by
- ii) length of waiting time.

4. Additional Outpatient Diagnostics / Treatment clinics or sessions

Any outpatient diagnostic or treatment services / sessions / clinics organised to meet demand must be open to both public and private patients called in order of clinical priority and length of waiting time.

Separate outpatient diagnostic or treatment services / sessions / clinics for private patients are not permitted within contracted hours or otherwise.

5. Common Waiting List is also a requirement of Consultant Contract 2008

Section 21 of Consultant Contract 2008 sets out the circumstances under which the Consultants employed under Consultant Contract 2008 may charge private fees in

relation to private patients undergoing diagnostic investigations, tests and procedures on an outpatient basis.

These are as follows:

- the volume of such private practice not exceeding the set ratio of public to private practice (a maximum of 30% for existing Consultants in employment when offer of Consultant Contract 2008 was made in July 2008, 20% for new appointees).
- all billing being processed by the Consultant in a manner that is satisfactory to the hospital and in the event that insufficient information is available for verification purposes recourse may be had to the measures provided for at Section 20 (d) and (e) of the Contract. Section 20 (d) notes that the Employer has full authority to take all necessary steps to ensure that for each element of a Consultant's practice, s(he) shall not exceed the agreed ratio.
- A common waiting list operated by the public hospital applying to both public and private patients undergoing diagnostic investigations, tests and procedures (including radiology and laboratory procedures) on an out-patient basis in public hospitals (including referrals from General Practitioners). Status on the common waiting list will be determined by clinical need only. The list will be subject to clinical validation by the relevant Clinical Director.

All outpatient diagnostics are included as regards the Common Waiting List. For example, outpatient diagnostic tests and procedures in cardiology, neurophysiology and gastroenterology.

6. Private Outpatient Clinics must be held outside contracted hours

Eligibility regulations give effect to legislation on the extent to which patients may avail of public or private services in the public health system. They are set out in a range of Department of Health Circulars.

These regulations state that private outpatient clinics may be held on the public hospital campus, however, such clinics must be held outside contracted hours.

Section 5 of Department of Health Circular No. 5 of 1991 states:

“Where there is a waiting list for outpatient treatment there can be no question of the patients being given preferential access to public clinics on the basis that they are private to the Consultant. A Consultant's private outpatients may be treated in a public hospital either:

- i) at a public clinic in accordance with their place on the overall waiting list for that clinic;
- ii) or at a time agreed with the hospital authority, outside of the Consultant's public commitment.”

7. Recording attendances at Private Outpatient Clinics on-campus

All persons attending private outpatient clinics on the hospital campus must be registered on the hospital information system in the same manner as those attending public outpatient clinics.

8. Each Consultant's entitlement to private practice

Taking account of the sections above, Consultants, depending on Type or Category of Contract may engage in private practice as set out below:

Consultant Contract 2008

i) **Type A Consultants** cannot engage in privately practice. Professional medical/dental practice carried out for or on behalf of the Mental Health Commission, the Coroner, other Irish statutory bodies¹, medical/dental education and training bodies is not regarded as private practice. In addition, the provision of expert medical/dental opinion relating to insurance claims, preparation of reports for the Courts and Court attendance is not regarded as private practice.

ii) **Type B Consultants** who:

a. In the post they now hold were previously employed under Consultant Contract 1997, the Academic Consultant Contract 1998, Consultant Contract 1991 or as Regional Consultant Orthodontists retain an entitlement to off-site outpatient private practice identical to that of a Category I Consultant under Consultant Contract 1997.

This means that they may engage in outpatient private practice in private rooms so long as it does not include day case procedures requiring anaesthesia and subject to the Consultant fully discharging his/her aggregate 37-hour weekly standard commitment as required by the Employer. They may not – other than providing occasional consultations at the request of another Consultant – work in private hospitals or clinics of any type.

They may also engage in in-patient, day-patient, out-patient or diagnostic private practice as appropriate in hospitals or facilities operated by the Employer, as part of such activities that arise as part of the employment contract (e.g. home visits) and in colocated private hospitals on public hospital campuses. Such private practice may not exceed 30% (or a lower figure as specified in their Contract) of the Consultant's clinical workload in any of his or her clinical activities, including in-patient, day-patient and out-patient.

OR

b. Commenced employment in a permanent, locum or temporary post under Consultant Contract 2008 on a Type B basis They may engage in in-patient, day-patient, out-patient or diagnostic private practice as appropriate in hospitals or facilities operated by the Employer, as part of such activities that arise as part of the employment contract (e.g. home visits) and in colocated private hospitals on public hospital campuses. Such private practice may not exceed 20% of the Consultant's clinical workload in any of his or her clinical activities, including in-patient, day-patient and out-patient.

They have no entitlement to private practice off-site.

iii) **Type B* Consultants** are Consultants who were previously employed in a permanent temporary or locum capacity under Consultant Contract 1997, the Academic Consultant Contract 1998 on a Category II basis, Consultant Contract 1991 or as Regional Consultant Orthodontists when the contract was offered in July 2008.

¹ An indicative list of such bodies is available from the HSE Employers Agency, 63-64 Adelaide Road, Dublin 2, tel: 01 6626966, web: www.hseea.ie

They retain an entitlement to off-site private practice identical to that of a Category II Consultant under Consultant Contract 1997.

This means that they may engage in off-site private practice in private rooms, hospitals clinics or otherwise subject to subject to the Consultant satisfying the employing authority that he or she is fulfilling their contractual commitment to the public hospital(s) and such private practice being confined to periods outside the aggregate 37 hour weekly commitment and other scheduled commitments to the public service.

They may also engage in in-patient, day-patient, out-patient or diagnostic private practice as appropriate in hospitals or facilities operated by the Employer, as part of such activities that arise as part of the employment contract (e.g. home visits) and in colocated private hospitals on public hospital campuses. Such private practice may not exceed 30% (or a lower figure as specified in their Contract) of the Consultant's clinical workload in any of his or her clinical activities, including in-patient, day-patient and out-patient.

Type B* is not available to Consultants who were not in post at the time of the offer of Consultant Contract 2008 in July 2008.

- iv) **Type C Consultants** may engage in off-site private practice in private rooms, hospitals, clinics or otherwise subject to the Consultant fully discharging his/her aggregate 37-hour weekly standard commitment as required by the Employer.

They may also engage in in-patient, day-patient, out-patient or diagnostic private practice as appropriate in hospitals or facilities operated by the Employer, as part of such activities that arise as part of the employment contract (e.g. home visits) and in colocated private hospitals on public hospital campuses. Such private practice may not exceed 20% of the Consultant's clinical workload in any of his or her clinical activities, including in-patient, day-patient and out-patient.

Consultant Contract 1997 / Academic Consultant Contract 1998

- i) **Category I Consultants** must devote substantially the whole of their professional time to the public hospital. They may engage in off-site outpatient private practice in private rooms so long as it does not include day case procedures requiring anaesthesia and subject to the Consultant satisfying the employing authority that he or she is fulfilling their contractual commitment to the public hospital(s). They may not – other than providing occasional consultations at the request of another Consultant – work in private hospitals or clinics of any type.

They may also engage in on-site private practice subject to the requirement that a Consultant's overall proportion of private patients should reflect the ratio of designated private beds.

- ii) **Category II Consultants** may engage in off-site private practice in private rooms, hospitals, clinics or otherwise subject to the Consultant satisfying the employing authority that he or she is fulfilling their contractual commitment to the public hospital(s).

They may also engage in on-site private practice subject to the requirement that a Consultant's overall proportion of private patients should reflect the ratio of designated private beds.

Consultant Contract 1991

- i) **Geographical Wholetime Consultants** must devote substantially the whole of their professional time to the public hospital. They may engage in off-site outpatient private practice in private rooms so long as it does not include day

case procedures requiring anaesthesia and subject to the Consultant satisfying the employing authority that he or she is fulfilling their contractual commitment to the public hospital(s). They may not – other than providing occasional consultations at the request of another Consultant – work in private hospitals or clinics of any type.

They may also engage in on-site private practice. The Consultant Contract 1991 does not specify any restrictions on same.

- ii) **Existing Wholetime Consultants** may engage in off-site private practice in private rooms, hospitals, clinics or otherwise subject to the Consultant satisfying the employing authority that he or she is fulfilling their contractual commitment to the public hospital(s).

They may also engage in on-site private practice. The Consultant Contract 1991 does not specify any restrictions on same.

9. Consultant Contract Type A and private patients

Volume III, Section 5 of Guidance to health service management on the implementation of Consultant Contract 2008 stated:

“Consultants holding Contract Type A may treat private patients. While such Consultants may not charge fees for such services, the Contract Type held by the Consultant does not alter the patient’s designation as a public or private patient.

Private patients continue to be liable for maintenance / accommodation charges when occupying private or semi-private accommodation.”

This statement does not reflect the approach to this issue adopted by the Department of Health and Children since March 2009 and guidance on this issue is amended as set out below.

In line with the legislation relating to health service eligibility and access to public hospital services and related Department of Health Circulars, the determination of the public or private status of a patient must be specified on admission.

Patients admitted by a Type A Consultant are deemed to be public patients for the duration of their hospital stay irrespective of source of referral, any request they may make to be treated privately or subsequent transfer – after admission – to a Consultant entitled to engage in private practice.

Patients admitted by Type B, Type B*, Type C, Category I, Category II or other Consultants entitled to engage in private practice may be determined to be either public or private patients.

A patient identified as a private patient will continue be liable for the fees of all Consultants contractually entitled to charge fees involved in his or her care. The patient is considered to be availing of private Consultant services where available.

Private patients continue to be liable for maintenance / accommodation charges when occupying private or semi-private accommodation.

Consultants holding Contract Type A may treat such private patients although they may not charge fees for such services.

Two examples of how the public and private status of patients is to be managed are set out below:

Scenario 1

A Patient is admitted under a Type A Consultant and is subsequently transferred to a Type B / Type B* / Type C / Category I / Category II Consultant. The patient holds private health insurance which he or she wishes to use. The patient remains public for the duration of their stay in hospital as they were admitted by a Type A Consultant.

Scenario 2

A Patient is admitted under a Type B / Type B* / Type C / Category I / Category II Consultant, has private health insurance and is being billed by the Consultant. The patient is also being billed by the hospital for private accommodation as they are accommodated in a designated private bed. The patient is transferred to Type A Consultant.

The patient remains private to the hospital if accommodated in a designated private bed and remains eligible for private fees from other Type B, Type B*, Type C, Category I or Category II Consultants should they provide any treatment or diagnostic services. The Type A Consultant cannot charge the patient any fees.

10. Semi-private patients

Where a patient is

- i) admitted under a Type B / Type B* / Type C Category I / Category II Consultant;
- ii) pays fees to a hospital for the provision of designated private accommodation and other services in addition to statutory charges; and
- iii) such fees are retained by the Employer in their entirety rather than being remitted to the Consultant,

then the patient may be considered public to the Consultant. Such patients are termed 'semi-private' in some institutions.

11. Regulation of Public : Private practice under Consultant Contract 2008

Section 20 of the Consultant Contract 2008 deals with the regulation of private practice and the mechanisms for ensuring compliance with the 80:20 / 70:30 ratio of public to private practice.

It should be noted that ratios that differ from 80:20 public to private are held by Consultants in employment when Consultant Contract 2008 was offered in July 2008 and who remain in the post they occupied at that time. Such ratios are not available to any Consultant taking up post under Consultant Contract 2008 since that time.

Section 20 of the Contract provides that the volume of private practice may not exceed the specified ratio in any of the Consultant's clinical activities including inpatient, day-patient and outpatient.

The volume of practice refers to patient throughput adjusted for complexity through the casemix system. It does not include non-clinical activities, nor does it apply to time.

Section 20 of the Contract states that the Employer has full authority to take all necessary steps to ensure that for each element of a Consultant's practice, s(he) shall not exceed the agreed ratio.

Other relevant sections include Section 4 b), which states that

“both the Consultant and the Employer shall co-operate in giving effect to such arrangements as are put into place to verify the delivery of the Consultant’s contractual commitments”

and Section 12 I), which requires the Consultant

“to participate in and facilitate production of all data/information required to validate delivery of duties and functions and inform planning and management of service delivery.”

12. Measurement of public and private practice under Consultant Contract 2008

Set out below is a list of key documents relating to the measurement and organisation of Consultant public and private practice:

- Department of Health and Children Circular No.1 of 1991 – recirculated in October 2008;
- Department of Health and Children Circular No.5 of 1991 - recirculated in October 2008;
- Sample Base ESRI template setting out 2006 private practice ratio, issued in August 2008
- HSE HiPE Casemix Unit – Guidance on Measurement of Public Private Mix – issued August 2008
- ESRI Information note on measurement of Inpatient & Daycase Activity – issued on 1st August 2008
- ESRI Explanatory Note on Individual Consultant Report – issued on 1st August 2008
- ESRI Guidance to Consultants on reporting of HIPE Data – issued on 1st September 2008
- Consultant Contract 2008 – Agreed Measurement systems for Public Private mix – 31st July 08,
- Consultant Contract 2008 – Management Guidance Vols I (25th July 2008), II (15th August 2008) and III (28th August 2008),
- Guidance on measurement of Outpatient and Diagnostic Activity – 29th September 08
- Template for monthly public private mix measurement report,

Each of these documents has been circulated to Hospital Network Managers in 2008 / 2009 and may be obtained from same or from email: andrew.condon@hse.ie .

13. Measurement of private outpatient activity under Consultant Contract 2008

Should Consultants engage in private outpatient practice on campus such practice will, like all other public or private activities undertaken on the public hospital campus, be subject to measurement as part of the 80:20 / 70:30 ratio of public to private practice under Consultant Contract 2008.

Measurement includes co-located hospitals on campus, private rooms on campus and private clinics on campus – with three exceptions. The exceptions are the private outpatient practice of existing Consultants in private clinics (as of 26th July 2008) on the campus of St James’, Beaumont and Cork University Hospital.

14. Aggregation of inpatient, outpatient, daycase and diagnostic data

Appendix VII of Consultant Contract 2008 notes that the:

“Public Private Mix Measurement Group shall consider whether such activities can be aggregated to form a single 80:20 public:private ratio. However, this is subject to the

implementation of Clause 20(b) with effect from 1st September 2008, in the absence of any agreed alternative measurement arrangement by that date.” (Appendix VII, Consultant Contract 2008)

Clause 20 b) of Consultant Contract 2008 states that:

“b) The volume of private practice may not exceed 20% of the Consultant’s workload in any of his or her clinical activities, including in-patient, day-patient and out-patient.” (Section 20, b) Consultant Contract 2008)

The Joint HSE / DoHC / IHCA / IMO Public Private Mix Group considered this issue in detail between July 2008 and January 2009 without reaching agreement. This means that that there should be no aggregation of inpatient, outpatient day-case or diagnostic data and the limit specified by the Contract should continue to apply to each of the Consultant’s clinical activities separately.

15. Aggregation of public private mix across multiple sites

Aggregation of the Consultant’s public private mix across multiple sites involves combining workload in two or more hospitals for an individual consultant (for example: in a situation whereby a consultant works in a largely elective hospital and a hospital with mostly emergency admissions).

Consultant Contract 2008 is not explicit on this issue and it was therefore considered by the Joint HSE / DoHC / IHCA / IMO Public Private Mix Group during 2009. In July 2009 the Group decided to refer the issue to the Chair of the Contract Implementation Group for a ruling. Further guidance will issue once a resolution has been arrived at. In the meantime, there should be no aggregation of public or private practice across multiple sites.

16. Ensuring compliance with Consultant Contract 2008 re private practice

Section 20 of Consultant Contract 2008 requires that the Consultant be advised on a timely basis if his or her practice is in excess of the 80:20 ratio of public to private practice in any of his or her clinical activities.

The date of 1st January 2009 is the earliest date that may be used when determining whether a Consultant’s practise in excess of the specified ratio.

Should any aspect of a Consultant’s practice be in breach of the ratio of public:private practice specified in their contract of employment, he or she should be advised of same by the Clinical Director / Employer.

In any event, the Consultant should receive written notification within at least 1 month of the issue being identified.

The written notification should:

- Note the ratio of public to private practice specified in that Consultant’s contract;
- Note the provisions of Section 20 of the Contract;
- State precisely where and to what extent the Consultant’s practice is in excess of the specified ratio;
- Request that the Consultant meet with the Clinical Director / Employer to discuss how the matter will be resolved;
- Note that the 6 month period provided for at Section 20 e) of the Contract has now commenced.

Should the matter be resolved within the 6 month period no further action is required.

However, should any aspect of the Consultant's practice continue to be in excess of the specified ratio after 6 months have elapsed, the Consultant should be issued with written notification of same, required to meet with the Clinical Director, Hospital Manager / CEO and other relevant staff and a timetable determined for resolution of the matter within the following three months.

Section 20 provides that if, after a period of 6 months and a further period of 3 months, the appropriate ratio is not established, the Consultant will be required to remit private practice fees in excess of this ratio to the research and study fund under the control of the Clinical Director. Such fees are likely to be calculated as a proportion of the Consultant's private fees pro-rata to the extent to which the Consultant is in breach of the ratio. Further guidance will issue on this point.

17. Reporting compliance with Consultant Contract 2008

Each Consultant in the employment of the public health service – irrespective of whether they hold Consultant Contract 2008 or not - should be issued with a public private mix measurement report every month. This should document their activity in relation to inpatient, daycase, outpatient and diagnostic activity over the previous three months.

The report is also issued to the relevant Clinical Director and Hospital Manager / CEO for consideration and to facilitate action to ensure with Consultant Contract 2008.

An overall status report is also prepared for internal HSE monitoring and management purposes and monitoring. From the January 2009 reporting period this report is considered as informing decisions by Clinical Directors and managers on individual Consultant compliance on a contractual basis. It will be provided monthly to the HSE Board, the Department of Health and Children and will be available under FOI.

18. Regulation of Public : Private practice under Consultant Contract 1997

Section 2.9.3 of the Memorandum of Agreement attached to Consultant Contract 1997 – and the Academic Consultant Contract 1998 - states that:

“With regard to on-site private practice, a consultant's overall proportion of private to public patients should reflect the ratio of public to private stay beds designated under the 1991 Health (Amendment) Act which requires that all public hospital beds be classified as public, private or non-designated.”

19. Ensuring compliance with Consultant Contract 1997 re private practice

Taking account of the above, should the proportion of private patients treated by a Consultant holding the Consultant Contract 1997 or the Academic Consultant Contract 1998 exceed the ratio of designated private beds, he or she should be advised of same by the Clinical Director / Employer.

In any event, the Consultant should receive written notification within at least 1 month of the issue being identified.

The written notification should:

- Note the ratio of public to private practice specified in that Consultant's contract;
- Note the provisions of Section 2.9.3 of the Consultant Contract 1997 / Academic Consultant Contract 1998;

- State precisely where and to what extent the Consultant's practice is in excess of the specified ratio;
- Request that the Consultant meet with the Clinical Director / Employer to discuss how the matter will be resolved;

Should the matter be resolved within a 6 month period no further action is required.

However, should any aspect of the Consultant's practice continue to be in excess of the specified ratio after 6 months have elapsed, the Consultant should be issued with written notification of same, required to meet with the Clinical Director, Hospital Manager / CEO and other relevant staff and a timetable determined for resolution of the matter within the following three months.

20. Employer to make provision for off-campus facilities for outpatient private practice

Consultant Contract 2008 states (at Section 21, Consultant Contract Type B, c) that:

“Where a Consultant holding Contract Type B cannot be provided with facilities on the hospital campus for outpatient private practice the employer shall make provision for such facilities off-campus, on an interim basis, pending provision of on-campus facilities.”

The nature of such provision is unclear and requires further discussion between health service employers at national level. Pending agreement on same, no local arrangements should be made.

21. Charging for use of public facilities

The Employer should have a policy regarding the use of public facilities by staff pursuing private business interests. While such a policy could provide for charges, the employer should be consistent in its application of charging – it should apply to staff equally and from a set date.

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