Private Practice in Public Hospitals: Should Senior Consultants be Prioritised?

Xidong Guo, School of Economics, University College Dublin, and Geary Institute of Public Policy

Sarah Parlane, School of Economics, University College Dublin, and Geary Institute of Public Policy

Introduction

In many countries, consultants employed by public hospitals are allowed to provide private, fee-paying consultations as part of their workload, that is, within the public hospital.[i] This specific form of dual practice enables the patients who can afford to pay for private consultations, either themselves or via some private health insurance, to gain faster access to outpatient consultations and elective care. Despite the fact that it is common practice in many countries, the provision of private care *within* private hospitals has not received as much attention in the literature.

Most countries lack the resources and capital needed to deliver a truly universal healthcare. Thus, governments typically settle for "second bests" intending to supply a high quality of care at the lowest possible cost. Within this context, dual practice has often been justified as a mean for public hospitals to attract and retain qualified consultants. In the UK, the National Health Service (NHS) has allowed publicly contracted consultants to treat private patients since 1948 (Klein, 2018). In Ireland, this is also possible since "The 1997 Consultants' Contract". When treatment in public hospitals is subject to long waiting times, the provision of private healthcare offers a valuable alternative access to care.[ii] This research proposes a normative analysis which investigates how private practices within a public hospital should be optimally managed and strategically allocated to junior and senior consultants, by exploring its impact on the total social welfare, which contains contracting costs, costs associated with waiting list, consultants' incentives, patients' welfare, and consumer surplus. Figure 1 below illustrates that the percentage of the population with unmet medical needs on average is much more prominent in the countries that forbid private practice *within* public hospitals.

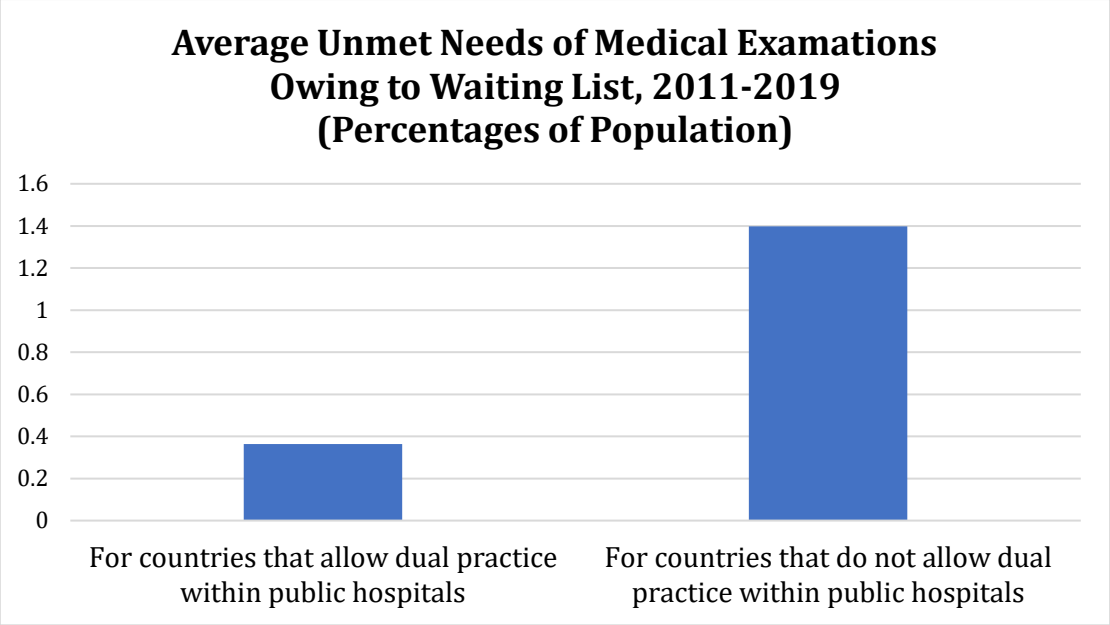

Figure 1: Unmet Needs for Medical Examination Owing to Waiting List

Notes: The chart above shows the average percentage of self-reported unmet needs for medical examinations because of waiting lists, between the countries who allow private practice within public hospitals and the countries who do not, from 2011 to 2019. We do not include the year of 2020 because of the effect from COIVD-19. Based on the availability of data from EuroStat, countries included here are: Austria, Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Luxembourg, Netherlands, Norway, Poland, Portugal, Spain, Sweden, Switzerland. For the information of the allowance of private practice within public hospitals, please see Appendix A.

Whether private practice systematically reduces the waiting lists is generally debatable. Iversen (1997) and Olivella (2002) show that waiting lists can be adjusted to reduce health care costs by inducing an optimal allocation of patients between *private hospitals* and *public hospitals* which are typically capacity constrained. Their analyses substantiate the fact that waiting times tend to increase in places where private care becomes available and more accessible because it reduces the demand for care within public hospitals thereby reducing their costs. More recently, Brekke and Sørgard (2007) and Morris et al. (2008) show that dual practices may incentivise consultants to curtail their supply of public care to stimulate the demand for private care. Along the same lines, González (2005) and Barros and Olivella (2005) show that it can lead to some form of cream-skimming as specific public patients are being persuaded to opt for private care. On the other hand, González (2004) provides a rationale supporting a more optimistic outcome showing that consultants may provide high-quality care to promote their reputation and boost their demand for private care.

The overall welfare implications of dual practice are, in general, unclear. Consequently, dual practice must be regulated when allowed. According to Mueller and Socha-Dietrich (2020), the regulation often takes the form of a cap imposed either on private earnings or on the percentage of fee-paying patients. In the UK, consultants with a full-time contract from the NHS, have a private income limited to 10% of their NHS salary (Raffel, 2007). In France, consultants who engage in private practice cannot earn a private income that is above 30% of their overall income (Kiwanuka et al., 2010). In Ireland, consultants who hold a "Type B

contract" can attend to, at most, 20 private patients out of 100 (Health Service Executive, 2019). It is also the case that, in many countries, dual practice within public hospitals is a privilege that tends to be exclusively offered to reputable senior consultants. These have better outside opportunities and may only accept an offer to work in a public hospital when granted a supplemental private income (see Mueller and Socha (2018)). This argument receives support from Paris et al. (2010) for the case of France and, for the UK, from a report of the British Medical Association (2021). In 2008, the Health Service Executive (HSE), which is the agent of the Department of Health in Ireland, implemented a restriction on private practice for newly hired consultants, which does not apply for consultants who joined the HSE before 2008. In particular, the senior consultants who opt for the "2008 Consultants' Contract" are entitled to a workload comprising at most 30% of private practice, while this ratio is only 20% for newly contracted consultants.

To the best of our knowledge, no paper has attempted to analyse whether senior consultants should be prioritised when considering dual practice, and, when so, whether they should get a higher private income supplement or attend to more private patients. This paper attempts to fill this gap. The analysis focuses specifically on the provision of private outpatient care within public hospitals and provides some insights as to its optimal management: who should be awarded a private practice privilege, and what form should it take? The analysis emphasises the consultants' productivity and incentives in a context where private care generates consumer surplus but waiting lists for public care generate welfare losses.

Model

We propose a mathematical model to analyse our research questions based on contract theory. We consider three stakeholders: The Health Authority (HA), consultants, and patients. The HA characterises the contracts that they offer to the consultants. These specify the fixed wage and the regulated private fee.[iii] Given her contract and her intrinsic ability, each consultant decides on the number of outpatients that she can attend to. Based on the private fee and given their willingness to pay for a private consultation, each patient can request to see a consultant privately or publicly. Public care is free of charge, but subject to longer waiting times which generates a utility loss. Private care is more immediate, but it is subject to a private fee. Each patients' willingness to pay for private care is the realisation of an identically and independently uniformly distributed random variable. This assumption is motivated considering that it depends on several characteristics such as, and among other factors, the patient's private insurance cover, personal preferences, age, and his past and present medical concerns.

We characterise the contracts that maximise the overall welfare which accounts for the consultants' utilities (or wellbeing), the patients' welfare, and the cost associated with waiting lists. Importantly, we also capture the fact that the provision of private care generates a consumer surplus gathered by patients willing to pay more for such a service than the fee they are charged. Finally, we deduct public healthcare costs which capture the fixed wages paid to consultants by the HA and which are subjected to a cost of raising public funds.[iv]

UCD **Geary Institute** for Public Policy, University College Dublin, Belfield, Dublin 4, Ireland. Phone +353 1 716 4615 Website: https://www.ucd.ie/geary Email: geary@ucd.ie.

Main Results

The results show that private practices lower public health expenditures as the private fee contributes to a consultant's overall earnings. Furthermore, the private fee entices consultants to attend to more patients, which leads to shorter waiting times and enables more patients to access healthcare, thereby increasing wellbeing. Therefore, as we assume that public funds are costly to raise, it would be optimal to maximise the consultant's private revenue, regardless of seniority, if we left aside concerns about the patient's economic consumer surplus. When this surplus is taken into consideration, we establish that the private fee, and consequently the consultant's private income, must be capped. We evaluate the optimal regulated fees in two situations. Firstly, we consider the possibility for the HA to rely on first-degree discrimination, which in this context means that the HA offers a contract to each consultant based on his or her characteristics and therefore, different consultants hold different exclusive contracts. Then we consider a situation similar to the one observed in Ireland whereby several contracts are made available, and each consultant can choose the one that suits her best.

Under first-degree discrimination, we show that the correlation between the private fee and the consultant's seniority or expertise could be either positive or negative. On the one hand, awarding senior consultants a higher private fee makes sense as patients are willing to pay more to see such consultants. The higher fee would entice the consultant to attend to more patients (public and private) and would lower waiting lists and public health expenses. However, on the other hand, the higher fee lowers the consumer surplus gathered by all of her private patients. We find that the negative effect could be the dominating one as indicated in Figure 2 which relies on some simulations of the model.

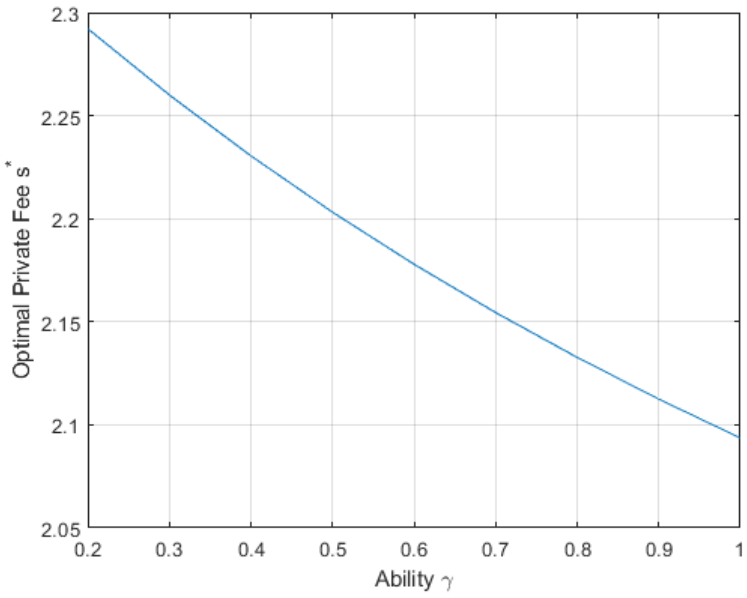

Figure 2: Optimal private fee as a function of the Ability of Consultants

In a context where the HA designs different contacts, these contracts must ensure that each type of consultant will be incentivised to select the contract designed for them. That is, the contracts must satisfy some envy-free constraints. We show that two situations can arise. In

UCD **Geary Institute** for Public Policy, University College Dublin, Belfield, Dublin 4, Ireland. Phone +353 1 716 4615 Website: https://www.ucd.ie/geary Email: geary@ucd.ie.

either, the fee charged by the less experienced, junior consultants must be set lower than the fee that these consultants would get under first-degree discrimination. In other words, junior consultants must get a lower private supplemental income when working alongside senior consultants. This is because senior consultants can extract rents and these rents increase with the private fee charged by their junior counterparts. The equilibrium can either be such that senior consultants charge a higher fee than junior consultants, or else both types of consultants charge the same fee. In the separating equilibrium (where the fees differ) senior consultants receive a higher private income and they attend to more patients. However, the number of private patients that they attend to is not necessarily larger than that of junior consultants as a lower proportion of their patients may be private patients. In the pooling equilibrium, where all consultants receive the same private fee, the senior consultants benefit from the presence of junior colleagues as they see their private fee rise when compared to what they would charge under first-degree discrimination.

Policy Implications for Ireland

Our research informs the debate on whether private practice *within* public hospitals should be permitted and, when so, it provides a blueprint for its optimal management. In Ireland, this topic has received much attention as a special commission working on behalf of the Irish government called for the complete removal of private practices from public hospitals.[v]

We show that the ability for consultants to access a private income incentivises them to treat more patients and lowers public health expenditures. However, to safeguard the private patients' consumer surplus, the private fee must be capped. As we do not account for capacity constraints which would restrict the number of additional patients being treated, our analysis emphasises the benefits that come from raising the fee more so than the losses. We can therefore conjecture that, in an economy where hospitals curtail the number of patients due to a lack of capacity, a cap of the fee is even more justified.

Clearly, the overall surplus is higher under first-degree discrimination as one does not have to take into consideration the envy-free constraints which lead to a second-best option. Thus, allowing consultants to choose a contract lowers social welfare. When discrimination is possible, senior consultants should receive a lower private fee when they attend to a much larger number of patients (and thus of private patients) than their junior colleagues. Under a low fee, they receive a lower revenue per patient but treat a larger proportion of private patients. When discrimination is either not possible or not allowed, the fee perceived by senior consultants is at the very least equal to the fee charged by junior consultants to limit the rents that the more experienced consultants can gather.

In general, we believe that our analysis emphasises the fact that the decision to remove private practices from public hospitals is one that deserves a particularly cautious analysis. It is potentially naïve to believe that the removal of private patients from public hospitals will shorten waiting times. The elimination of private care within public hospitals can trigger a rise in the fees charged by private hospitals as these are not operating under perfect competition. This would reduce the affordability of private care and lead to an increase in the number of patients seeking public care.

References

Aran, M. and Rokx, C., 2014. TURKEY ON THE WAY OF UNIVERSAL HEALTH COVERAGE THROUGH THE HEALTH TRANSFORMATION PROGRAM. World Bank Group [online]. Available from: https://documents1.worldbank.org/curated/en/243161468308038702/pdf/913260WP0UHC0C00Box385331B00PUBLIC0.pdf [accessed 11 May 2022]

Barros, P. P. and Olivella, P., 2005, Waiting lists and patient selection. Journal of Economics and Management Strategy, 14, pp. 623–646

Brekke, K.R. and Sørgard, L., 2007. Public versus private health care in a national health service. Health economics, 16(6), pp.579-601.

British Medical Association, 2021. SAS doctors and private practice[online]. Available from: https://www.bma.org.uk/advice-and-support/private-practice/working-in-private-practice/sas-doctors-and-private-practice [accessed 11 May 2022]

Garattini, L. and Padula, A., 2018. Dual practice of hospital staff doctors: hippocratic or hypocritic?. Journal of the Royal Society of Medicine, 111(8), pp.265-269.

González, P., 2004, Should physicians' dual practice be limited? An incentive approach. Health economics, 13(6), pp.505-524.

González, P., 2005, On a policy of transferring public patients to private practice. Health Economics, 14, pp. 513–527.

Health Service Executive (2019), *Consultants' Contract* [online]. Available from: https://www.hse.ie/eng/staff/resources/terms-conditions-of-employment/ccontract/consultant-contract-2008-25th-june-2019.pdf [accessed 27 February 2020]

Immergut, E.M. and Comisso, E., 1992. Health politics: interests and institutions in Western Europe. CUP Archive.

Iversen T. (1997), "The effect of a private sector on the waiting time in a national health service," Journal of Health Economics 16, 381-396

Kiwanuka, S.N., Kinengyere, A.A., Rutebemberwa, E., Nalwadda, C., Ssengooba, F., Olico-Okui, Pariyo, G.W. (2010). Dual practice regulatory mechanisms in the health sector: a systematic review of approaches and implementation. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London

Klein, R., 2018. The public-private mix in the UK. In The public private mix for health (pp. 53-72). CRC Press.

Morris S, Elliott B, Ma A, McConnachie A, Rice N, Skatun D, et al. Analysis of consultants NHS and private incomes in England in 2003/4. J R Soc Med 2008; 101: 372–380

UCD **Geary Institute** for Public Policy, University College Dublin, Belfield, Dublin 4, Ireland. Phone +353 1 716 4615 Website: https://www.ucd.ie/geary Email: geary@ucd.ie.

Mueller, M., & Socha, K. (2018). OECD report: Assessing private practice in public hospitals [online]. Available from: https://assets.gov.ie/26530/88ebd7ddd9e74b51ac5227a38927d5f9.pdf [accessed 08 Feb 2022]

Mueller, M. and K. Socha-Dietrich (2020), "Reassessing private practice in public hospitals in Ireland: An overview of OECD experiences", OECD Health Working Papers, No. 118

Ofer, G., Greenstein, M. and Rosen, B., 2006. Selecting your Surgeon: the Private–Public Mix in Public Hospitals in Jerusalem; Considerations of Efficiency and Equity. CESifo Economic Studies, 52(3), pp.513-547.

Olivella P. (2002), "Shifting public-health-sector waiting lists to the private sector," European Journal of Political Economy 19, 103-132

Paris, V., Devaux, M., & Wei, L. (2010). Health systems institutional characteristics: a survey of 29 OECD countries.

Raffel, M.W. ed., 2007, Health care and reform in industrialized countries. Penn State Press.

Sutton, M. and Long, J., 2014. International models of career structure for medical specialists, other tenured medical posts and general practitioners in public (funded) health systems

The Competition Authority, 2005. Guidance in respect of Collective Negotiations relating to the Setting of Medical fees [online]. Available from: https://www.ccpc.ie/business/wp-content/uploads/sites/3/2017/04/Medical-Fees-Guidance-Note.pdf [accessed 09 June 2022]

Topeli, A., 2010. Intensive Care Medicine in Turkey. HealthManagement [online]. Available from: https://healthmanagement.org/c/it/issuearticle/intensive-care-medicine-in-turkey [accessed 11 May 2022]

UCD **Geary Institute** for Public Policy, University College Dublin, Belfield, Dublin 4, Ireland. Phone +353 1 716 4615 Website: https://www.ucd.ie/geary Email: geary@ucd.ie.

Appendix A

Table 1: Private Practice in OECD Countries

Countries	Private Practice allowed?	Private Practice within public hospitals allowed?
Australia	√	√
Austria	√	√
Belgium	√	√
Canada	×	×
Chile	√	√
Costa Rica	○	
Czech Republic	√	×
Denmark	√	×
Finland	√	×
France	√	√
Germany	√	√
Greece	○	√
Hungary		×
Iceland	√	×
Ireland	√	√
Israel	√	√
Italy	○	√
Japan	○	√
Korea		×
Latvia	√	
Luxembourg		√
Mexico		×
Netherlands	√	√
New Zealand		×

Norway	√	×
Poland	√	×
Portugal	○	√
Slovenia	○	
Spain	√	×
Sweden	○	Was √, then ×
Switzerland	√	√
Turkey		Was √, then ×
United Kingdom	√	√

Note: The tick √ stands for "Yes, always". The circle ○ stands for "Yes, in some circumstances only". The cross × stands for "No". The question mark ? stands for "Unclear, please refer to footnote". The blank cell refers to "No information found". We exclude American, Colombia, Estonia, Lithuania, and Slovak Republic, because there is no information about these countries from OECD survey.

List of sources of information in Table 1

Main sources: OECD Survey on health system characteristics 2008-2009 and 2016.

Chile: OECD Health System Characteristics Survey 2016, Question 31 (Comments)

Finland: Please see Sutton and Long (2014) and Garattini and Padula (2018).

Germany: Please see Garattini and Padula (2018).

Ireland: Please see Irish consultant's contract 2008 from Health Service Executive (2019).

Israel: Please see Ofer et al. (2006).

Italy: Please see Garattini and Padula (2018).

Norway: Please see Garattini and Padula (2018).

Sweden: According to Immergut and Comisso (1992), senior consultants could treat private patients even within public hospitals. According to OECD Survey on health system characteristics 2008-2009, Sweden no longer allows this private provision of care.

Turkey: Please see Topeli (2010) and World Bank Group report by Aran and Rokx (2014), new arrangements were introduced in 2010, which required public doctors to practice exclusively in the public sector.

UCD **Geary Institute** for Public Policy, University College Dublin, Belfield, Dublin 4, Ireland. Phone +353 1 716 4615 Website: https://www.ucd.ie/geary Email: geary@ucd.ie.

[i] Table 1 in Appendix A shows that there are 26 OECD countries that allow private practice (within public hospitals or outside public hospitals). There are 16 OECD countries that allow the provision of private care within public hospitals.

[ii] The outpatient waiting time measures the period between a referral decision from GP and an assessment by a consultant.

[iii] According to The Competition Authority (2005), in Ireland, the private fee is negotiated between consultants' representatives and private health insurance; sometimes public hospitals will be involved. Considering the "law of supply" in Economics, the HSE could indirectly regulate the private fee by restricting the workload of private practice by consultants (as stated in 2008 Consultants' Contract).

[iv] The cost of providing care is taken into consideration by the consultant.

[v] See the Report of the Independent Review Group established to examine private activity in public hospitals, available here: https://www.gov.ie/en/publication/28ddfd-report-of-the-independent-review-group-established-to-examine-privat/

UCD **Geary Institute** for Public Policy, University College Dublin, Belfield, Dublin 4, Ireland. Phone +353 1 716 4615 Website: https://www.ucd.ie/geary Email: geary@ucd.ie.