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Ms Catherine Smyth
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Re: Ref (1545 PAC33)

Dear Ms Smyth

I refer to your recent correspondence to Mr. Bernard Gloster, Chief Executive Officer, Health Service Executive, requesting a *briefing on any cost to the State arising with regard to patients treated in private hospitals during the period that the Safety Net Agreement was in place.*

Please find below a briefing on the matter as requested.

If any further information is required, please do not hesitate to contact me.

Yours sincerely,

Ray Mitchell

Ray Mitchell
Assistant National Director
Parliamentary Affairs Division

A detailed briefing on any cost to the State arising with regard to patients treated in private hospitals during the period that the Safety Net Agreement was in place

We refer to your letter of 5 January 2024 in relation to correspondence received by the Public Accounts Committee ("**PAC**") from an individual referring to a complaint made by the individual in question, to the Financial Services and Pensions Ombudsman ("**FSPO**") and subsequent decision of the FSPO. The complaint, and the FSPO decision, centre on the treatment of the individual by a consultant as a private patient during the period that the Safety Net Agreement was in place in 2020, and the refusal of the individual's private health insurer to provide cover and to discharge the consultant's fees for the procedure in question.

I note that the individual in question contends that his insurer's refusal to provide cover, and the FSPO's decision in respect of his individual complaint, leads to a conclusion that "*the HSE and Exchequer paying for hospital care that insurance should have paid for a period of 3 months at the height of Covid*".

With respect to the individual concerned, this conclusion is incorrect and appears to arise from a misunderstanding of the terms of the agreement in place as between the HSE and the private hospitals at the relevant time (30 March 2020 – 30 June 2020), and how it was operated.

Before turning to address the specific issues, it is necessary to remind the PAC of the context within which the arrangements with the private hospitals were rapidly put in place at the end of March 2020. These arrangements were a necessary and prudent response to the immediate demands of the COVID-19 pandemic and Government concerns over the capacity of the public hospital system to cope with the pandemic. At this time the epidemiological projections for COVID-19 indicated that the State faced a surge in cases, with the potential to overwhelm the public health system. The European Centre for Disease Prevention and Control was clear that all European health systems faced such a risk at the time, with stark images from some of our European neighbours showing evidence of their hospital networks under immense pressure. It was recognised that, from both a health and policy perspective, the HSE needed additional acute hospital capacity to seek to ensure that the Irish hospital system was not overwhelmed by the anticipated steep surge in the number of Covid-19 patients requiring hospital care, and to protect other urgent time-critical emergency services. In this context, the HSE put in place the necessary temporary arrangements with the private hospitals to support the public system in providing essential acute hospital services.

The HSE agreed Heads of Terms with private hospitals for provision of support to the public system in March 2020 (the "**HOT**"). Under the HOT, which have been laid before the Houses of the Oireachtas, the facilities and capacity of Relevant Hospitals were made available to the HSE. This gave the HSE immediate access to an additional 2,500 beds, over 100 of which were critical care beds, on a cost-only, open-book accounting basis. Thankfully, the public health measures adopted so assiduously by the public meant that the anticipated surge did not occur in the manner feared in early 2020. On 29 May, 2020, Government decided to conclude this arrangement on 30 June 2020, with the additional capacity in the private hospitals remaining available to the public system until that date.

You will appreciate that the HOT provided that the HSE would, inter alia, respect the confidential commercial nature of the dealings with each private hospital. As such it is not possible to disclose dealings with individual private hospitals, however as the HOT has been laid before the Oireachtas (available at https://opac.oireachtas.ie/AWData/Library3/Documents%20Laid/pdf/DOHdoclaid160420_160420_154056.pdf) we will refer where appropriate to relevant provisions of the HOT.

The HOT provided that the Relevant Hospitals (as defined in the HOT) were to provide a fully public service, and that all patients were to be treated as public patients during the term of the HOT (clause 1.4). As such, the Relevant Hospitals were precluded from treating patients privately during the period of the HOT.

It is important to understand that the HOT was an agreement between the HSE and the Relevant Hospitals only. Private consultants were not a party to the agreement. However, the HOT (at clause 4.4.) made explicit provision for continuity of care for patients who were either in the hospital at the inception of the HOT or who required treatment during the course of the arrangement. In this context, pursuant to clause 7.4 of the HOT, private consultants associated with the Relevant Hospitals were offered locum public-only contracts for the duration of the arrangements under the HOT. Where a consultant accepted the contract, he or she would continue to treat patients, but as public patients only. The number of private consultants was circa 550, of which 291 took up the offer of the public patient-only consultant locum contract.

For further context, the HOT were entered into against the background of a direction from the National Public Health Emergency Team ("**NPHET**") issued on 27 March 2020 to the effect that "*all non-essential surgery, health procedures and other non-essential services be postponed*". This recommendation was replaced on 5 May 2020 in relation to acute care, with a recommendation that delivery of acute care be determined by appropriate clinical and operational decision making.

The foregoing means that those consultants who did not sign up to an agreement with the HSE may have continued to treat patients privately and/or may have resumed doing so after the updated NPHET advice of 5 May 2020, where they were of the view it was clinically warranted.

The HSE had no control over private consultants who did not agree to the locum public-patient only contract envisaged under Clause 7.4 of the HOT, and who continued to treat patients privately. Therefore, it is entirely a private matter as between a consultant, their patient, and the patient's health insurers as to whether or not a consultant was entitled to charge for services during this period, and if these charges were recoverable under the patient's health insurance policy, and not a matter for the HSE.

As described above, arising from the public health advice at the time, under the HOT the Relevant Hospitals were precluded from treating patients privately during the period of the HOT, and it was clear that the Relevant Hospitals were not entitled to charge hospitals fees for private patients during the period. Indeed, there is no allegation that they did so here. This is evidenced by the exchange of correspondence between the private hospital and the insurance provider as cited at page 6 of the FSPO decision as to the nature of the arrangements under the HOT, and the fact that the fees the subject of the individual's complaint was the Consultant's private invoice only.

Furthermore, it is noted that the procedure the subject of the individual's complaint was an *outpatient* surgical ophthalmic procedure, with no admission to the Relevant Hospital. Charges levied by private consultants in respect of such outpatient procedures were (and are) a matter entirely as between the individual and the consultant in question, and are entirely separate and distinct to any charges levied by the Relevant Hospital. In this regard, there is a separate charging regime for admitted patients and outpatient services. Charges in respect of patients admitted into care in a Relevant Hospital are normally levied by the Relevant Hospital, to include the consultant charge. The HOT governed the costs recoverable by the Relevant Hospital during the currency of the HOT and their normal charging regime did not apply.

Outpatient charges are entirely separate and are billed directly by the consultant and not the Relevant Hospital. Such charges would be billed directly to the patient or submitted to the patient's insurer for payment. Such charges are entirely extraneous to the Relevant Hospital.

Neither the Relevant Hospitals nor the HSE had any way of knowing what patients the consultants were treating and charging for outpatient visits, and crucially the HSE had no liability for such charges under the HOT.

To be clear, contrary to the assertion of the individual complainant, the HSE did not pay consultants' private fees for the provision of private services during the term of the HOT.

In the circumstances, the individual's contentions in relation to the quantum potentially at issue, and the wider public issues are misplaced, and arise from a misunderstanding of the HOT and how it operated at the time. This is echoed in the submission made by the provider in the complaint before the FSPO that the vast majority of consultants did not issue private fees for procedures carried out during the period the HOT was in force (see page 8 of the FSPO decision).

In relation to the specific question of the costs to the State arising from the HOT, as set out above the fees to be paid to the Relevant Hospitals was limited to a reimbursement of the Relevant Hospitals' operational costs (within the meaning of the HOT) on a cost-only, open-book accounting basis. The costs paid under the HOT were in the region of €285 million.

Health Service Executive
January 2024