Submission on the Removal of Private Practice from Public Hospitals

February 2018

Executive Summary

The Irish Nurses and Midwives Organisation (INMO) has consistently, over many years, argued for the introduction of single-tier health system in this country. This system would provide the full range of health services, from cradle to grave, with access being solely determined by need and not ability to pay.

The INMO, together with other unions, NGOs and other interested parties, hold the view that our current two-tier health system is deeply flawed, and inequitable, with speed of access to services being primarily determined by one's ability to pay or hold private health insurance. (INMO, 2014)

The two-tier public health service has created instability, inequality of access and dissatisfaction amongst patients, clients and staff. The commitment to a single-tier health system, where access to care is determined solely by need and not ability to pay, is most welcome and will be strongly supported by the INMO. This system must offer, at its core, speedy access and quality assured services to every citizen, if it is to become a cornerstone of Irish society.

In determining the impact of removing the private practice from public hospitals, a number of key areas must be taken in to consideration:

- equity of access to health care services must be prioritised for all in our society and in particular, vulnerable sections of society;

- funding arrangements for the acute health services must include an increase in employer PRSI to make up for loss in revenue associated with loss of private bed utilisation;

- Adequate staffing, bearing in mind the consequential resources required as a result of the removal of private practice from public services, must at all times be maintained as a priority in ensuring safe patient care.

1.0 Eligibility, Access and Equity

1.1 Introduction

The current Irish health system is wholly inadequate when considering eligibility, access and equity to health services. The INMO supports social solidarity in the delivery of health care. In that context social solidarity forms the centrepiece of our vision for the organisation and delivery of health services.

The current public/private mix of acute hospital care clearly undermines equity of access to health care for many in this country and therefore requires change. Many specific barriers impeding access to care will require attention over the coming decade if this is to become a reality. Recognition of the scope of the problem in turn gives hope that the required actions will be taken to realise the important goal of equity of access.

1.2 Health Inequalities

It is well established, the ongoing provision of private beds in public acute hospitals, teamed with the lack of access to primary care services, has led to the marginalising of those in our society who cannot afford to pay for care. This results in access to care being determined based on an ability to pay arising from resources in public facilities being consumed by private patients. Equity in access to and delivery of healthcare is not just a lofty social good, there are tangible improvements for society where equity of access is achieved; “There is now evidence to show that more equal societies do better across a range of outcomes, including health. Equality is good for everyone in society” (Burke and Pentony, 2011). In this context, private health insurance, and the use of this insurance to accelerate access to the public system, contributes heavily to the inequities which prevail, and, “there is a clear disparity between those with and those without private health insurance across income and education levels” (Finn and Hardiman 2011). Poor health outcomes have been the ultimate result of the country’s two-tier system and a person’s socio-economic status has become a measure of the health care they receive. If there were any doubt on this point, evidence from the Central Statistics Office (CSO) shows clearly that persons living in the most deprived areas have the lowest life expectancy (CSO, 2010). “Similarly, the Institute of Public Health’s (IPH) work on chronic diseases shows higher rates of both coronary heart disease (CHD) and diabetes in the most deprived fifth of the population compared to the rest (Burke and Pentony, 2011). Other sections of society are adversely affected by the current system. For example, the All Ireland Traveller Health Study found mortality rates significantly higher among Travellers than among the general population (UCD, 2010). Overall, the key message is that inequities relating to access matters, they are perpetuated, by among other things, the usage of capacity in public facilities by private patients and the use of health insurance in this regard, and the outcomes are felt by those who have least within our society who bear great suffering and live shorter lives.

1.3 Capacity

The impact of removing private care from the public system will have a positive effect on the capacity of the public health service. The current capacity challenges, combined with chronic staff shortages, underdevelopment of primary care, and an ageing population, are increasing pressures on the acute setting. According to the OECD, the occupancy rate for Irish acute beds is considerably above average at 93.8%, and approximately 94%, one of the highest in

the OECD countries (OECD, 2017). The capacity report published in January 2018, confirms that without reform over 7,000 acute beds will be required to cater for projected demand and that even with significant reform, analysis is showing a "net requirement for acute hospitals beds in the order of 2,590 in the public system by 2031." (Department of Health, 2018). This points to the pressing need to take urgent action to realise all available capacity in the public interest.

The current level of capacity is wholly inadequate, and this is putting extreme pressure on public hospitals and their emergency departments throughout the country. The crisis within our emergency departments continues to cause serious concern. The Irish Nurses and Midwives Organisation (INMO) have recorded a total of 2,408 patient on trolleys during the first week of 2018. This marks an increase of 221, or 10%, on the same period in 2017. Additionally, while the emergency departments amount to a visible manifestation of the problem, overcrowding has now moved to inpatient wards with patients accommodated in corridors, behind doors, and in other inappropriate spaces throughout hospitals, with no attendant increases in staff to care for their needs.

Patient and staff safety issues, are a real feature of this overcrowding and must be addressed by increasing capacity, which is supported by appropriately along with necessary supporting funded staffing measures.

An issue which additionally touches on the capacity of public hospitals is the bed stock in residential care services, with the Capacity Review identifying a need for a 43% increase in residential care beds and a 120% increase in homecare over the period to 2031, and this is taking account of reforms which have not yet begun. The current residential care service capacity is inadequate and arising from this inadequacy people must often remain in hospital beds for longer than necessary, and this again evidences the urgent necessity to realise all available public hospital capacity.

It is difficult to determine the exact number of beds or bed days which will become available from the removal of private facilities from public hospitals. This uncertainty arises from a mix of models used, with some devoting entire wards to private patients, and other realising private income from the use of private and semi-private rooms on otherwise public wards. However, whichever model is used in a particular hospital, access to a single occupancy room or dual occupancy room should be determined based on the needs of patients in a hospital at a particular time and should have no reference to economics. Additionally, where private wards are in existence, these will be immediately available for public usage and thus increase capacity. Thus, as an interim measure, and to ensure that capacity is utilised on a needs basis, and that all available capacity is realised on that basis, it is necessary to remove private services from these facilities. However, given the current capacity issues, a significant expansion is required within the acute hospital services.

The capacity of the private hospitals to admit the patients currently classified as private would need to be determined, and the actual practicability of transferring patients from ED on presentation will not always be suitable, therefore the elective admissions are the most likely group to benefit from this process and as the main problems with capacity at present is mainly ED medical admissions not having sufficient beds.

1.4 Waiting Lists

Privatisation within Ireland's public hospitals has ensured a system where ability to pay determines health outcomes. According to the Euro Health Consumer Index, "In 2017, Ireland is alone in last position for accessibility" (Björnberg, 2018). Almost 680,000 people remain on waiting lists for various procedures, according to the figures published in October 2017 (National Treatment Purchase Fund, 2017). The National Treatment Purchase Fund (NTPF), at the time, although a welcome and necessary development to ensure treatment was not further delayed for patients, is inefficient and ineffective in addressing the access issues long term.

Removing private care from public hospitals will assist in reducing waiting times, and in addition ensure that persons are taken from the waiting list in rotation and on the basis of need, not the ability to pay. However, there are a number of other facets which will have to be addressed, such as the development of primary care services, universal health care, staffing and funding, if an equitable access is to be sustained.

1.5 Primary and Community Care

It is essential that in removing private health care from public hospitals, that current underdeveloped primary care services be addressed. Ireland needs to have a "model where the vast majority of healthcare is provided in the community" (Houses of the Oireachtas, 2017). As we face an increase in chronic diseases, co-morbidities and an ageing population, this development is now more important than ever.

Ireland has the only European health system that does not offer universal coverage of primary care (Thomson et al., 2014). This has put excessive pressure on the acute care services. Access to primary care remains expensive. The cost associated with preventative and primary care constitutes, for many, a cost prohibitive barrier to accessing healthcare in Ireland. Primary care has been identified as the most effective way of addressing inequalities in health and in disease. It deals with health problems at the lowest level of complexity.

The cornerstone of any single-tier universally accessible health service will be the development of a primary care health service which works, at a minimum, on a seven-day basis, with access being available on a 24/7 basis in major urban areas.

2.0. Legislative and Contractual Issues

2.1 Introduction

There are several important areas requiring legislative reform which are associated with the Sláintecare Report and its proposed programme of reform. They relate to key values embedded into the Irish health system, new governance structures, funding, and organisational realignment.

2.2 Two-Tier System

Entitlement to healthcare is subject to a complex system of eligibility categories. There is no universal legal entitlement to health and social care in Ireland. The system of 'eligibility' is

often determined by Health Act 1970 and its many amendments. Care is provided based on medical cards, which are awarded on income grounds, or illness status (e.g. Long Term Illness Scheme). There is also the automatic right for under 6s and the over 70s, not to mention the GP only cards. But even this eligibility does not guarantee access. Variation in access by type, location and volume of service leads to long waits or complete unavailability. (Trinity College Dublin, 2017). Almost 40% have eligibility for free health care and another 47% have taken out private health insurance (Health Insurance Authority, 2017).

This two-tier hospital access and care is reinforced by legislation and government agreed contracts and it is imperative that work begins on unravelling these immediately. The INMO would call on the Sláintecare Implementation Office to identify all the legislation that needs to be amended and commence working on updating these as priority.

2.3 Contracts

There are several key pieces that are required for private care to be removed from public hospitals. It is imperative that negotiations commence with interested parties, which can facilitate this legislative reform.

2.3.1 Consultant Contract

The Sláintecare Report proposes that public hospitals be used to treat public patients, with private patients being treated in private hospitals. Ultimately this will require renegotiation of contracts for those consultants who have private practice rights in public hospitals.

2.3.2 GP Contract

The Sláintecare Report includes an increased reliance on primary and community care and the introduction of free (at the point of use) GP care for all which will require negotiation with the GPs.

2.3.3. Direct Employees

The INMO calls for all health professionals, providing primary care services in teams, to be directly employed. Privately employed practice nurses must be employed by the state and under the direction and governance of the public health system, this will assist development and expansion of the nursing led services that are required and proven to benefit patients and reduce costs of care.

GPs and consultants must be afforded the opportunity to move from existing contracts to a direct public contract, working on a seven-day roster system, while existing contracts for both GPs and consultants, could be retained but not renewed.

In order to ensure that the public system can employ appropriately qualified and expert health professionals in an internationally competitive market there must be a realistic assessment of the remunerative package needed to deliver this reality. There is evidence of myopic, parochial and rhetorical debates which compare salaries of professionals on a domestic basis, however, these debates are of no use as they fail to appreciate and address the realities of internationalised labour markets, a fact which must be addressed to ensure that we do not lose our domestic health professional graduates and are able to recruit internationally to draw graduates here.

2.4 Tax Reliefs

The INMO calls for a phased abolition of all tax reliefs pertaining to private health insurance as well as plans to end the contracting of services to provide direct care and a phased ending of subventions to private nursing homes. The realisation of a single tier system requires that all public resources be devoted to realising existing capacity, increasing capacity, and ensuring the safe deployment of public capacity. The continuation of perverse incentivisation of private facilities and services merely add complexity to the system, diverts necessary resources, and ultimately perpetuates inequality.

2.5 Statutory Basis for Sláintecare

As per the Sláintecare Report, work needs to begin on drawing up legislation for all the areas listed in the recommendations including the Irish (Sláinte) Health Act, which will provide the legislative basis for a universal entitlement to health and social care for everyone living in Ireland.

It is crucial to have the legislation that will underpin the statutory basis of Sláintecare as legislation is needed on the national health fund; accountability in the Department of Health and Health Service Executive; on national standards in clinical governance etc. These are of vital important to ensure a proper functioning health service.

3.0 Recruitment and Retention of Personnel

3.1 Providing appropriate nurse and midwife staffing is fundamental in providing a safe and effective health service. Currently, there is a chronic shortage throughout the health service. The recruitment and retaining of nursing staff is the key to the realisation of the necessary increased capacity outlined in the Capacity Review and the simple reality is that, under the current conditions, the Irish health service is failing to either attract or retain nurses.

3.1.1 Acute Services

Private beds are staffed by nursing/ midwifery staff who are allocated to the hospital compliment therefore allocating public patients to the beds, as currently happens on occasion, will not require new contracts etc for nursing/midwifery staff. They are public servants employed in various hospital and assigned to work in private wards. However, the ward staffing may need to be reviewed as the compliment of staff assigned may need to be increased if the bed numbers increase from 5 bed wards to six bed wards, for example. Any developments required in terms of staffing acute services must be done within the context of the work of the Taskforce on Staffing and Skill Mix.

Research, again and again, identifies the importance of ensuring appropriate nurse/midwife staffing levels and the benefits this delivers to a health service, those utilising the service, and the costs of those services. The evidence associating positive patient outcomes with a higher number of registered nurses is clear (Aiken et al., 2014, Ball and Catton, 2011). Research also shows that an increase in nurse staffing is associated with increased patient safety and that a lower staffing ratio is directly associated with higher mortality rates (Aiken et al., 2002). Lower nurse staffing is associated with other adverse events and poor quality of care as well as poor patient outcomes including increased risk of falls. Other negative patient outcomes

associated with inadequate nurse staffing levels includes increased rates of pneumonia, urinary tract and surgical site infection and pressure ulcers are affected by lower staffing ratios. Inadequate staffing levels were also identified by an independent Inquiry as a key contributing factor to the 'appalling' care experienced by patients at Mid Staffordshire NHS Foundation Trust (INMO, 2014).

In terms of midwifery, similar evidence is available. Research has shown that midwifery-led care can lead to benefits for mothers including less use of analgesia, fewer episiotomies or instrumental births and that lower staffing levels are associated with adverse outcomes in terms of safety and experience. (Gerova et al., 2010).

The National Midwifery Strategy must be implemented in full and form part of the new models of care with effective utilisation of resources. The recommended ratio of midwife to births of 1 to 29.5 which is recognised as being an optimal staffing level for quality assured care must be achieved in Ireland and the current figures indicate that we have a minimum deficit of 220 WTE posts. The number of midwives must be increased in line with this report.

3.1.2 Community Services

In terms of staffing the primary and community care services, the Capacity Review states that demand for public health nursing appointments is forecast to rise by 46%, this is without taking into account the proposed model of care within the community. Evidence regarding the requirements and needs of safe staffing within primary care can be limited. The evidence we do have, suggests some worrying trends, which require attention. The Missed Care report published in 2016, stated that over 50% of respondents indicated missed care in their previous working week (Phelan and McCarthy, 2016). A study in the UK found that nurses working in the community rating there care as 'fair' or 'poor' had higher workloads then those rating their care as 'excellent'(Ball et al., 2014).

3.1.3 Workforce Plan

A key area for development must be the health workforce plan which should clearly identify the human resources for health required to staff this expanded, comprehensive, public service. Overseas recruitment (apart from the ethical dilemmas it creates) cannot be relied on to staff our health service. It is imperative to educate and retain people in this country. This will require the new health service, which will be the largest employer in the State, to be a world class employer offering excellent pay and other terms and conditions of employment.

4.0 Current and Future Funding Arrangements

4.1 Introduction

The Irish health care system has long been criticised for a number of weaknesses including access based on ability-to-pay rather than clinical need. Politically, the process of change to delivering a single-tier world class public health service with access based on clinical need will require fundamental reform of the current funding model.

4.2 Current Funding Arrangements

The current health service provision is highly unusual and unique to Ireland. It is publicly funded through taxation; however, a large amount of private patient care is carried out in public hospitals thus making the vast majority of private care publicly funded also. (Burke, 2009). The current manner in which health services are funded, delivered and structured firmly privileges private patients over public patients.

4.3 Possible Funding Options

It is generally agreed that there are four options from which health services can be funded: general taxation, social insurance, private insurance and out-of-pocket payments. Systems of financing universal health insurance are identified as the predominant method of financing and most commonly follow one of two approaches, which can be broadly categorised as tax-financed systems or social insurance-financed systems.

The INMO supports the establishment of a single-tier health service funded from general taxation acknowledging that various models of general taxation may be deployed to achieve this objective. (INMO, 2016)

The funding option of preference in the Sláintecare Report, is by way of the establishment of a National Health Fund, which includes a mixture of general taxation and specific earmarked funds (to be decided upon by Government).

4.4 Revenue from Private Patients in Public Hospitals

The annual revenue from the treatment of private patients in public hospitals amounts to more than €600 million, or some 15% of the public acute hospital funding. Specifically, the revenue paid to public hospitals by private insurance companies amounted to €649m in 2016 and is estimated to be €621m in 2017. (Houses of the Oireachtas, 2017).

With the removal of private patient care from public hospitals, there would be a deficit in hospital budgets, however, the real figures of cost associated with the use for private patients of public hospital diagnostics, medications, cleaning, lighting, heat etc, are underestimated and would, it would appear, not be billed to insurance companies on an organised or routine basis within the current public hospital system.

The preferred method of replacing this revenue, is through increasing employer PRSI towards the EU effective average rate. While Budget 2018 did state that Employer PRSI is set to increase by 0.1% per year over the next 3 years, to 11.05% by 2020, this increase is earmarked for the National Training Fund. The INMO proposes that higher increases could be levied on employers and ringfenced for public health care.

The Minister for Social Protection gave figures with estimates for the increased yield from differing % rates of Employer PRSI increase. She stated that Class A employers pay PRSI at the rate of 8.5% where weekly earnings are between €38 and €376. Once earnings exceed €376, the rate of employer PRSI is 10.75%. The increase in PRSI yield to increasing the PRSI rates by 1%, 2% or 5% are shown in Table 1 below.

% Increase in Rate of Employer PRSI	Increased Yield from Increase in 8.5% lower rate	Increased Yield from increase in 10.75% Higher Rate	Total Increased Yield
1%	€36m	€683m	€719m
2%	€72m	€1,366m	€1,438m
5%	€181m	€3,416m	€3,597m

Table 1: Yield from Increase in PRSI these estimates are based on the data available and reflect macro-economic indicators for 2018 only. (Written Answer, 13 July 2017).*

This increase of employer's contribution, would not lead to competitive concerns within the EU as, the increased rate would remain within the EU average employer's contribution.

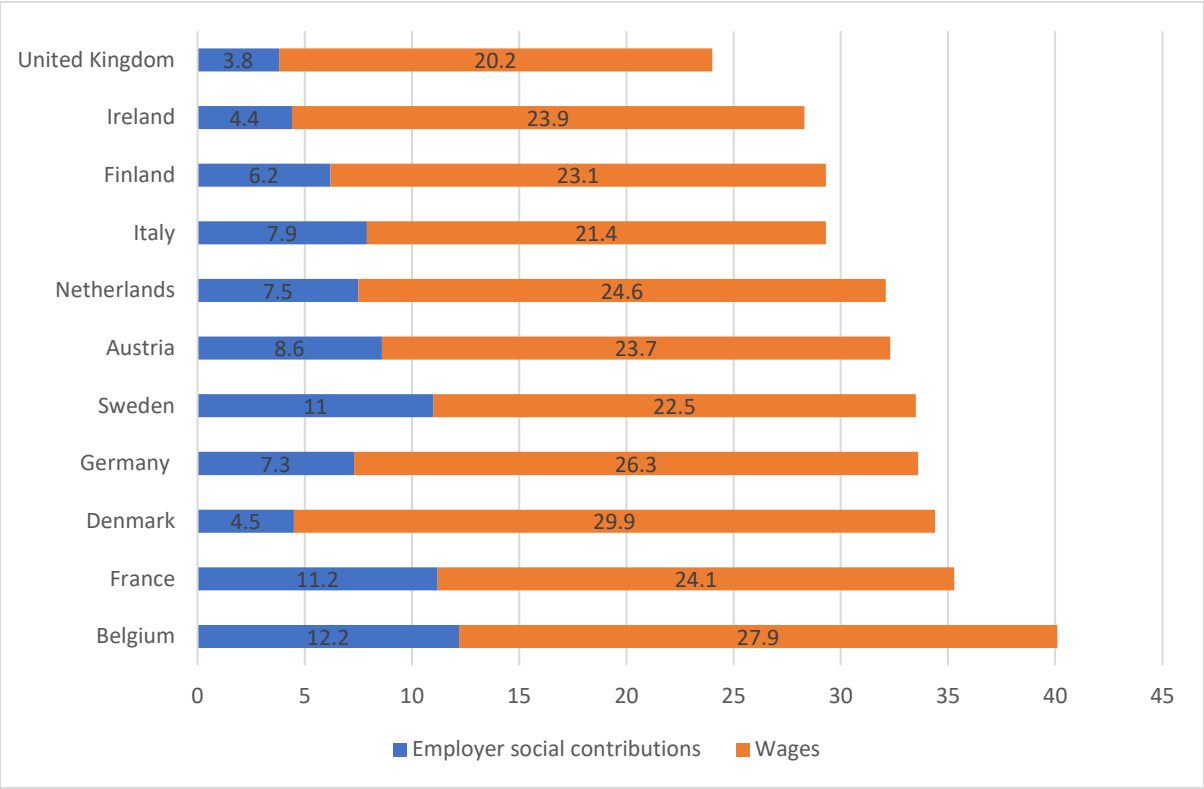

Figure 1. Average Hourly Costs in Euro, 2016 (Eurostat, Labour cost levels by NACE Rev. 2 activity, 2017)

The lowest increase of 1% would offset the loss of private income in public hospitals and is the preferred option to ensure the burden of providing equitable health care and increased capacity is not only placed on working people.

4.5 Ring Fencing Funds

A tax on sugar-sweetened drinks is due to be introduced next April to coincide with the introduction of a similar tax in the UK. Department of Finance figures show a 5c increase on a 330ml can of a soft drink liable for the tax would raise €42.2m per annum. While the Department of Finance has specifically stated that ringfencing the proceeds would reduce the flexibility of the Government to prioritise and allocate funds as necessary at a particular time, the INMO believes that these funds should be reinvested in health promotion and health protection. The Sláintecare Report suggests also that funds should be earmarked/ring fenced to health care priorities, such as expanded primary and social care, palliative care and mental health.

The INMO suggests these funds should be used to expand the Health and Wellbeing budget specifically the universal child and wellbeing service. This service is based on hiring additional community registered general nurses which would free up public health nurses who have specialist child health training to carry out their child health work and develop universal child health and wellbeing services. Investing in children's health is a potentially valuable economic investment. Making greater investments in children's health results in better educated and more productive adults. This sets in motion favourable demographic changes and shows that safe guarding health during childhood is more important than at any other age. Poor health during children's early years is likely to permanently impair them over the course of their life, which has economic repercussions in the future and thus implications on the health service usage.

4.6 Budget Pooling

With the wide variety of processes involved in resourcing care in silos, financial factors are frequently a barrier to effective integrated care. Siloed budgeting and lack of integration between state agencies are cited as obstacles to integrated care. (Houses of the Oireachtas, 2017) This is especially the case when there are different funding mechanisms for different channels. The INMO recommends that pooled budgets across primary and social care should be commenced. As recommended in the Sláintecare report, the INMO would support a phased pooling of funding to support integrated care. Pooled budgets are seen as critical to the seamless delivery of integrated services as money in the pool loses its health/social identity and staff can decide how the pooled resources are spent across the spectrum of health or social care services. (Pike and Mongan, 2014)

4.7 Tax Reliefs and Other Private Subventions

The INMO recommends that this new funding model include the following:

- The phased abolition of all tax reliefs pertaining to private health insurance
- The ending of any contracting for services to provide direct care: and
- The phased ending of subventions to private nursing homes.

It is recognised that these reforms will take an extended period due to a range of factors including contracts/bed stock and development of new facilities. However, the savings made would allow for increased expansion in entitlements for all patients.

5.0 Operational Matters including Specialist Services

5.1 Introduction

While developing the organisational structures, it is essential that current public health services are maintained and fully supported until alternative models of service are developed.

5.2 Impact on Staffing

It is imperative that where there is a change in bed designation from private to public, that adequate staffing must be in place. This staffing should be based on the Staffing Taskforce and as part of the overall health workforce plan.

5.3 Public /Private Working Relationships

The potential increase in levels of activity in private hospitals may place consequential pressures for critical care in public hospitals. With this in mind, there must be a service agreement between public and private hospitals to offset this, which for example may grant access by public hospitals to private facilities for diagnostic imaging services.

5.4 Waiting lists Management

In respect of the designation of private to public, access on the waiting lists should exhausted a rotational and clinical need basis with no “leapfrogging” by private patients.

6.0 Practical Approaches To Removing Private Practice from Public Hospitals Including Timeframe and Phasing

6.1 Engagement

Timely and adequate engagement will be required with any party where contractual measures are currently in place as regards private patients in public hospitals.

6.2 Legislative Changes

Coalesce the necessary legislation for the introduction of increased employer PRSI in a timely fashion in order to replace revenue that is lost in the public hospitals from the removal of private patients. It is essential this happens to ensure there is no shortfall in funding.

Conclusions

Healthcare is a social good and a human right which, if provided in a quality assured way, brings societal, communal and economic good to a nation. A properly funded health system, which is required to be accountable, productive and efficient, must also be transparent, must guarantee equity and must guarantee world-class outcomes. (INMO, 2014)

It is imperative while removing private practice from public hospitals, that the aim of protecting vulnerable sections of society, through ensuring equity of access and access based on clinical need are to the forefront of all decisions.

The establishment of a single-tier, quality-assured and universally accessible healthcare system must be underpinned by a willingness to commit to additional resources, in terms of finance, staffing and infrastructure.

All approaches taken to funding must secure and maintain the support of both the political system and the taxpayer. The shift to funding, through general taxation, and the phased abolition of tax reliefs and subventions for healthcare, must be undertaken in a very open and transparent manner if it is to enjoy community support. Revenue lost must be in the context of current costs to the system of this type of health care provision and in any event an increase in employer PRSI would offset this loss.

The move to the single-tier health system will benefit all citizens in Ireland and the realisation of this must be articulated and worked towards by Government. In order to have a healthcare system where access is determined by need and guaranteed to be speedy, then there must have a much wider, broader structure where diagnostics, day procedures, in-patient procedures, all underpinned by strong investment in health education and promotion programmes, are accessible regardless of where one lives or what one can afford. in the country.

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