Mr. Ronan Toomey
Secretary to the Review Group examining Private Practice in Public Hospitals
C/O Room 424
Department of Health
Hawkins House
Hawkins Street
Dublin 2, D02 VW90
(to IRGPrivatePublic@health.gov.ie)

5 February 2018

Dear Mr Twoomey,

I am writing in a personal capacity in response to the call for submissions from interested parties to the Review group on the impact of the introduction of the "Sláintecare" proposals on private practice in public hospitals. I am a Consultant Surgeon in a Dublin teaching hospital with over 30 years experience of working in the public hospital system.

I note that the terms of reference specify that "an independent impact analysis should be carried out of the separation of private practice from the public hospital system, with a view to identifying any adverse and unintended consequences that may arise for the public system in the separation."

I note the six themes you have identified in your call for submissions.

I am concerned that the constraints on the process, specifically the requirement to "identify adverse and unintended consequences that may arise for the public system", could result in advice to the Minister that, if it is focussed on the **public hospital system** only, fails to consider all the factors which might impact on access to care for public patients.

I have no doubt that there will be many well researched and data driven submissions to the review group to facilitate your making an appropriate recommendation to the Minister. However, I would like to draw the review groups attention to a number of points in relation to one aspect only. That of equity.

In terms of considering equity of access, I suggest that it is important to consider equity of access of public patients to hospital services, regardless of how that is funded or how the hospitals are configured.

Funding arrangements: Funding currently comes from:

1) taxation (to which taxpayers contribute broadly on a means basis),

2) from private health insurance (PHI to which those with the means and inclination, contribute on a voluntary basis) and

3) from out of pocket expenditure though that forms a very small part of the hospital spend.

The hospitals are provided directly by the state (statutory hospitals), by the private voluntary sector (via a service level agreement) and the (for profit) private sector.

While the taxation stream primarily funds the statutory and voluntary hospitals, these hospitals also generate funds from PHI which in total account for about 20% of their turnover. Private hospitals primarily generate their funding from PHI but they also, in practice, are funded from taxation through the National Treatment Purchase Fund, for example. While the global amounts paid by the NTPF are available, the turnover of private hospitals is not readily available to me and it is unclear

what proportion of the overall funding of private hospitals derives from public funds. Perhaps this is available to the committee from the submission of the Independent Hospitals Association. The amount of funding proposed for the NTPF in 2018 is substantially greater than recent years but comparable to several years ago.

In addition, private hospitals have historically benefitted from public subsidy through tax relief on capital, for example.

Obviously, PHI carries significant tax relief for the individual subscriber (which is a further public subsidy of private care) and the Revenue Commissioners will be in best placed to advise the committee of the cost of this subsidy.

Thus, not only is there funding of the "public" hospitals from PHI but there is also funding of private hospitals from taxation. It would be easy to ignore the latter if the review focusses on the public system only.

Reasons for purchasing PHI: There is very little data on which to rely when trying to understand why consumers choose to purchase PHI. While there are claims about the "quality of care" and "access to expertise", it seems likely that most those purchasing insurance do so because of concerns about access.

Many private hospitals (and some public hospitals) are JCI-accredited and this has some value as a marker for the quality of the processes of care. Following an abortive attempt to bring in public hospital accreditation over a decade ago, there has been no further progress in this regard. While "quality of care" has been proposed as another reason for consumer choice, it seems more likely that consumers perceive that private medicine will be more "Consultant provided". In the main, the consultants providing private care are the same individuals providing care in the public hospitals. If there is any evidence of a quality deficit in public hospitals or private hospitals, then I presume that it will also be the intention of the Minister, the Department, the private hospitals and the HSE to address any deficits so that the standard of care provided in the two sectors is comparable.

Based on the stated aims of the "Sláintecare" proposals, it is intended that access to care in public hospitals will be improved with shorter waiting lists and times proposed. While this would be a very welcome development for patients and for all involved in the provision of care in public hospitals, this may remove a significant incentive for consumers to purchase PHI. Nothing so far proposed suggests that those with PHI (or with means above a threshold) will be excluded from public hospital care as is currently the case with GP/primary care. Thus, if the service improves in public hospitals as outlined, the demand is likely to increase as consumers cancel expensive PHI and opt for "free" treatment in the public sector.

Similarly, the stated aims of "Sláintecare" in relation to "Consultant provided care" will remove, or at least reduce, the need to access private hospitals in order to experience Consultant provided care.

All of this is means that the improvements in healthcare provision set out in "Sláintecare" are likely to transfer some demand for services from private to public hospitals. One must also consider the possibility that, if access to services improves to the extent described in "Sláintecare" over the next ten years, PHI providers, who are currently banking excess income as reserves against future claims, will be able to retain the excess and simply exit the market taking those reserves with them.

Impact on current activity: There is nothing in the "Slaintecare" proposals to suggest that patients with PHI currently attending public hospital will all necessarily transfer to private hospitals. Indeed,

under current provisions those patients with PHI will still be equally eligible for care in public hospitals.

All those patients who currently opt for private care in public hospitals are eligible for treatment as public patients. In many cases, those same patients are likely to be admitted to public rather than private hospitals including:

1. emergencies (up to 70% of public hospital admissions)
2. following trauma (especially major trauma)
3. those with complex or chronic conditions requiring multidisciplinary care or time critical repeated interventions (e.g renal failure, diabetes, cardiac failure)
4. those with extensive multi-morbidity requiring interdisciplinary treatment for other conditions (e.g elective orthopaedic surgery),
5. those with complex conditions (e.g. certain malignancies, vascular surgical conditions, neurosurgical conditions) requiring multidisciplinary care.
6. patients in remote locations including most of those outside the larger cities.

Even where some might choose to seek treatment in private hospitals, many PHI policies limit which treatments are covered, or how many times they may be admitted (either for one admission or cumulatively). In addition, there has been a considerable expansion of the number of "cheaper" policies aimed at younger subscribers following the introduction of lifetime community rating. These policies typically provide limited cover often with large deductibles leading, one might suspect, to a significant growth in income for insurance companies (particularly in the commercial sector). However, these policies may not allow affordable access to care in private hospitals when patients become ill leading them to fall back onto the public service.

The number of truly "elective" admissions as a proportion of the total number of admissions in public hospitals is quite small. The proportion of those patients currently treated in public hospitals funded by their PHI requiring truly elective care who would move to private hospitals under the new proposals is unknowable. In addition, there are already some patients who have PHI but who choose not to use it and opt for public care for a variety of reasons.

While data from the HSE may help in determining the likely impact, it would be wise to consider that the possibility that a significant proportion (or the majority or even the vast majority) who are currently designated “private” may continue to choose treatment in public hospitals without the obligation to pay any additional charges under the "Sláintecare" proposals.

In the short term (if those patients also choose to continue their PHI), this could result in a large windfall for the PHI providers and there does not appear to be any reliable mechanism to recover this funding. In the case of VHI, these funds will ultimately revert to the state. However, in the worst-case scenario, more than €700million per year currently paid into the public sector by PHI could be lost from healthcare provision into insurance company reserves. This is in addition to the care already provided to those with PHI who opt for public treatment meaning that up to €1billion per year could be lost from the healthcare system into PHI reserves.

While I recognise that this is theoretical, there is no mechanism to prevent this other than the assumption that the amount paid into PHI will be balanced by the expenditure. There is no obligation on PHI providers to stay in the market or to transfer their reserves should they exit the market. Measures for risk equalisation have been largely ineffective to date.

Equity: As long as all patients are entitled to access to public hospitals that is free (or largely free) at the point of use (regardless of means) and those with the means to afford PHI may also access private hospitals, there will continue to be inequity in access to hospital care.

Indeed, because of the loss of PHI income to public hospitals, such changes could make the situation considerably worse. It will require a significant injection of taxation-based funding (equal in size to the current income from PHI) just to stand still – roughly €700M. The PHI income that would have come from insured patients who are treated in public hospitals will not fund activity in private hospitals either (as the patient is being treated in the public sector).

From the perspective of the patient who needs care, equity of access to public beds, does not equate equity of access to healthcare. The current ad hoc method of procurement of private capacity for public patients (e.g. the NTPF) will do little to address inequity, however much it could be scaled up.

Radical change: I do not believe any of the foregoing provides any justification for continuing the existing structure and funding models based on equity grounds. However, I do not believe that the "Sláintecare" proposals provide any confidence that equity will be addressed. At best the proposals will move from the current "3-tier" system by copper fastening a "2-tier" system. This is likely to further undermine the admittedly shaky form of social solidarity that currently exists in healthcare.

A reliable method of transferring funding from the voluntary PHI sector basis is required to ensure that funding of "public" and "private" patients remains linked. A system based on a **direct levy on PHI policies** (rather than the current state subsidy) which is used to top up (rather than replace) state funding for public healthcare would be one means of sharing the funding more equitably. It would be socially progressive as the levy would only be paid by those with the means to do so. It could avoid the need to restrict access to "public" hospitals for those with more means and, in this way, maintain social solidarity. The income from the levy would have to large enough to replace the existing PHI funding to public hospitals but would also grow if PHI levels were to increase. It could also act as a disincentive to purchase PHI and the impact of that on availability of hospital care is unclear.

An alternative would be to replace the current mixed funding model with a **universal insurance fund**. Payments into the fund would be means based (social solidarity) and care would be provided on the basis of need. Many of the problems in the previous proposals for Universal Health Insurance related to the inefficiency that multiple competing for-profit insurers would create. While a single state provided insurer may cause difficulties with EU competition issues and more imaginative solutions to this may have to be explored.

I do not think it is credible to ignore private healthcare and PHI and focus only on the public funding of services in public hospitals as, I suggest, is largely the case with the Slaintecare" proposals. I believe such an approach creates a considerable financial risk to the state and will allow inequity in access to hospital care to continue and may exacerbate that inequity.

Yours sincerely,

Professor Sean Tierney FRCSI (11985)

Consultant Vascular Surgeon.