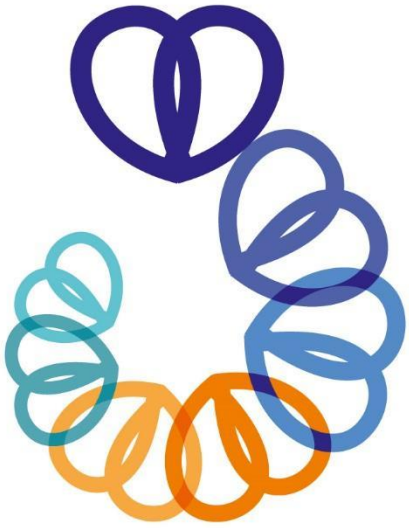

Health
Reform
Alliance

Background to the Health Reform Alliance

The Health Reform Alliance brings voices from across the health, social care, charity and academic sectors together to call for Government reform of Ireland's health and social care system.
The current members are the Adelaide Health Foundation, Asthma Society of Ireland, Age Action, The Alzheimer Society of Ireland, the Irish Cancer Society, the Irish Heart Foundation, Shine, Samaritans Rehab and the Neurological Alliance of Ireland.

Alliance members share a common belief that reform is needed to create a more equitable system.

We have developed a consensus on the values which should underpin reform and to advocate for systems, services and policies that could best deliver it. The five key principles set out by the Health Reform Alliance for reform of our health and social care systems are:

- The health and social care system treats everyone equally.
- The health and social care system is focused on the needs of all social groups in society.
- People have an entitlement to health and social care, free at the point of access.
- The different elements of the health and social care system work together and are connected.
- The health and social care system is a universal, publicly funded system.

The Alliance seeks to ensure the best possible health outcomes for the people we represent who rely on our health and social care systems. We wish to ensure that their voices are heard in the conversation on health reform.

The Alliance welcomed the establishment of the Oireachtas Future of Healthcare Committee as a sign of broad cross-party commitment to reform Ireland's health and social care system. The report of the committee, published on 30th May 2017, is an important blueprint for ending the two-tier health system and moving towards a health and social care system based on need and not on ability to pay, where people have equal access to quality care.

Consultation

The Health Reform Alliance welcomes the opportunity to make a submission to the consultation on private practice in public hospitals, arising from the establishment of the Independent Review Group by the Minister for Health. In keeping with the recommendation of the Sláintecare Report, the HRA supports the phased elimination of private care from public hospitals, which would lead to an expansion of the public system's ability to provide public care. Indeed, its proposals to disentangle public and private acute care by phasing out private work in public hospitals between years 2 and 6 of the report's programme and to replace private funding in public hospitals, will help in shifting to a universal, publicly funded system, which is not based on profit. However, we are concerned that the recommendation to retain the tax relief for private health insurance could undermine the intention behind these proposals.

In its consideration of the separation of private practice from the public acute hospital system, we believe that the Independent Review Group should, where possible, consider the timeframes and proposals in the Sláintecare Report so that any approaches taken can work alongside the ambitious 10-year plan for reform. This is especially important in the context of the development of the programme office and the appointment of the Sláintecare Executive Director.

Introduction

This submission maps the extent of private provision in public hospitals currently, examines the drivers of, and demand for, private provision, describes how it takes place and presents the views of the Health Reform Alliance on how to remove private practice from public hospitals. The submission also draws upon the recommendations of the Sláintecare report and Oireachtas hearings in terms of the implications of private practice for the public system and for the efficiency, accessibility and quality of the services delivered to the public.

It is our belief that key considerations when conducting an impact analysis on the separation of private practice from the public acute hospital system must include:

- To what extent, and in which areas, is private provision obstructing the increase of capacity in the public sector in the delivery of services in hospitals?
- Is a reliance on private provision through the National Treatment Purchase Fund and consultants, among other, hindering or underming the development of public capacity because of the resource allocation?
- What are the consequences of private provision involvement for the quality, accessibility and efficiency of services to patients, based on their need, as opposed to ability to pay?
- What is the impact of private practice in public hospitals on health inequalities?

The Irish System currently

The Irish health system is a complicated mix of public, private and voluntary care providers, with a lack of clarity and transparency in paths in, and through, the system for patients and users of the health services. Part of that complexity is the existence and overlap of private health insurance with the public health system, that people who can afford to pay privately can get those diagnostic tests quicker, get to see a specialist quicker and if insured may be able to get their treatment quicker.

At a time of increased waiting lists, stretched capacity and projected increase demand for healthcare services, it is important that access to publicly provided health services and facilities are based on clinical need, and not ability to pay. The OECD has noted that low hospital capacity and the two-tier health financing system, which gives patients with private health insurance preferential treatment, is contributing to long waiting times for outpatient treatment and inpatient surgery.[1] The capacity issue, they believe, stems from a dearth of investment in infrastructure.

The *Report of the Expert Group on Resource Allocation and Financing in the Health Sector*[2] noted that the current financing system lacks transparency, gives rise to serious inequities in access to care and results in numerous anomalies for users of care. For example:

- over two thirds of the population pay for GP and many community-based services on a pay-as-you-go basis, which takes no account of their ability to pay.
- individuals who can afford private health insurance gain access to some hospital services quicker than those with equivalent health needs who do not have insurance.

Currently, in Ireland, 45% of the population have private health insurance yet it contributes to just 9% of overall cost of healthcare. [3] Indeed, the introduction of lifetime community rating has likely

[1] OECD/European Observatory on Health Systems and Policies (2017), Ireland: Country Health Profile 2017, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels. http://dx.doi.org/10.1787/9789264283435-en

[2] Department of Health and Children. (2010). *Report of the Expert Group on Resource Allocation and Financing in the Health Sector*. July 2010. Available from: http://health.gov.ie/wp-content/uploads/2014/03/resource_allocation_report_hiRes.pdf (p. xi)

perpetuated the two-tier system, by forcing people into private insurance. The Health Reform Alliance certainly do not envisage a scenario where there is no role for private health insurance.

In consideration of its role and that of private provision in public hospitals, it is our belief that it should be an optional decision to supplement publicly provided care in public hospitals as opposed to being a necessity to buy private health insurance because of difficulties accessing the public hospital system. In other health systems, if a person had private health insurance, they would more than likely be treated by a private consultant in a private hospital.

In Ireland, private health insurance cover dropped from 52% of the population in 2007 to just under 44% at the end of 2014, reflecting the effects of the recession, but in September 2016, it showed a slight increase to 44.8%.[4] In its examination of private health insurance, and its role in reinforcing the two tier health system, the Slaintecare Report found that the only other countries with similar optional private insurance spending patterns to Ireland were France and Slovenia. However, where private health insurance in Ireland enables faster access in the public system, in these countries, private health insurance is supplementary and contributes to out of pocket payments. On the other hand, research has shown that low-income groups are less likely to have private health insurance and rely on the public health system. In the absence of systemic reform that redresses the inequities in the health system, it is less likely that care is provided wholly on medical need and more likely that those who need the services most will be disproportionately affected.[5]

The impact of low bed capacity, and the underdevelopment of primary care, cannot be divorced from the perpetuation of the two-tier health system in Ireland. If faster access to hospital services is a strong contributory factor in people buying private health insurance, then the strain on hospitals through high occupancy rates and emergency department presentations, leads to cancellation or postponement of elective procedures, thus leading then to people missing out on vital treatment when needed. 95% of all hospital beds in acute care are occupied on average throughout the year, which is much higher than the EU average (77%) and leaves the acute system effectively operating at capacity.[6] Essentially, this has led to this system being referred to as “inpatient hospital insurance that people are scared into taking out because it gets them faster access”.[7]

Given that much of the private health care in Ireland is provided through the public hospital system, this, in effect, means that the provision of private health care is subsidised by public money.[8] This situation is unsustainable.

Perverse Incentives

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[3] Dr Sara Burke.(2016). *Inequality and Access to Healthcare*. Presentation to Oireachtas Committee on the Future of Healthcare. Available from: https://www.oireachtas.ie/parliament/media/committees/futureofhealthcare/Dr-Sara-Burke,-Centre-for-Health-Policy-and-Management,-TCD.pdf

[4] Oireachtas Committee on the Future of Healthcare. (2017). Sláintecare Report. May 2017. Available from: https://www.oireachtas.ie/parliament/media/committees/futureofhealthcare/Oireachtas-Committee-on-the-Future-of-Healthcare-Slaintecare-Report-300517.pdf

[5] Burke, S. and Pentony, S. (2011). Eliminating Health Inequalities – A Matter of Life and Death —*TASC 2011. TASC. Available from:* http://hdl.handle.net/10147/301846

[6] OECD/European Observatory on Health Systems and Policies (2017), Ireland: Country Health Profile 2017, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels. http://dx.doi.org/10.1787/9789264283435-en

[7] Dr Sara Burke contribution at Oireachtas Committee on the Future of Healthcare on Wednesday 5th October 2016. Available from: http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/DebatesWebPack.nsf/committeetakes/FUH2016100500002?opendocument#B00200

[8] Burke, S. and Pentony, S. (2011). Eliminating Health Inequalities – A Matter of Life and Death —*TASC 2011. TASC. Available from:* http://hdl.handle.net/10147/301846

Within the Irish health system, a number of perverse incentives have been identified, which exacerbate and perpetuate the two-tier health system. Often, narratives surrounding policies that favour the role of private provision tend to rely on arguments based on efficiency gains, reductions in public expenditure and reductions in waiting lists in public hospitals. However, Eurofound note that where care has been purchased from private hospitals with the aim of reducing waiting lists in public hospitals, for example, it is not entirely clear whether this is a successful strategy, and whether it is more cost-effective than investing in developing the capacity of public hospitals.[9]

Concern around perverse incentives in the Irish context has been expressed by a number of experts, as well as by the Committee on the Future of Healthcare in the Slaintecare Report:

"Current policy which removed the 20% limit of private work in public hospitals combined with the current practice of setting private patient income targets for public hospitals are perverse incentives."

Consultants

One such perverse incentive has been identified as relating to consultants and their contracts. Much of the overlap between public and private care in the public hospital system is perpetuated by the demand for top specialists in public hospitals - by having arrangements in place to retain these professionals, they are then available to offer care to public patients. Indeed, previous health strategies identified the dichotomy in the public hospital system as necessary to ensure that the public and private sectors could share resources, clinical knowledge, skills and technology.[10]

With the revision of the consultation contract, provision was made for a new 'public only' category whereby a consultant is not permitted to treat patients on a private basis. However, currently the majority (81%) of consultants have contracts which enable them to work privately in public hospitals.[11]

One of the criticisms levelled against the current arrangements is the fact that consultants are paid a salary no matter how many or few public patients they treat, and a fee for each private patient. "Not only do private patients get privileged access to public-hospital care but this private care is subsidised by public money in the form of tax relief for private health insurance. The unorthodox public-private mix directly contributes to the high cost and poor access to care in the Irish public health system." [12]

Most recently, consultants have been the focus of a Prime Time investigation, leading to a subsequent Joint Oireachtas committee on Health hearing. Speaking during these hearings, the Department of Health acknowledged that:

[9] Eurofound (2017), Delivering hospital services: A greater role for the private sector? Publications Office of the European Union, Luxembourg.

[10] Department of Health and Children. (2001). Quality and Fairness. A Health System for You. Health Strategy. Available from: http://health.gov.ie/wp-content/uploads/2014/03/strategy-report.pdf

[11] Oireachtas Committee on the Future of Healthcare. (2017). Sláintecare Report. May 2017. Available from: https://www.oireachtas.ie/parliament/media/committees/futureofhealthcare/Oireachtas-Committee-on-the-Future-of-Healthcare-Slaintecare-Report-300517.pdf

[12] Burke, S. (2017). Government policy hurts public patients. The Irish Times. Available from: https://www.irishtimes.com/opinion/hospital-consultants-are-hurting-public-patients-1.3301271

"it is clear that the arrangements that are in place, or enforcement of these, are not robust enough to deliver compliance in all circumstances. As a result, some consultants have engaged in private practice activity at levels that exceed the levels provided for in their contracts."[13]

On the ending of the provision of private care in public hospitals, the Slaintecare report makes specific recommendations on this issue. It notes that the development of elective only hospitals in each Hospital Group could create new opportunities for the development of consultants' specialist skills through elective work in the private sector, thus offsetting the need to supplement their public work with elective work in the private sector. Similarly, the report recognises that existing contracts may change through negotiation and recommends enhanced public only contracts for new recruits.[14]

Stretch Income Targets

The issue of stretch income targets has also recently been the subject of much discussion in both the Joint Oireachtas Committee on Health and the Oireachtas Committee on the Future of Healthcare.

The Health (Amendment) Act 2013 was implemented to address the issue identified by the Comptroller and Auditor General and provided for the charging of all private patients in public hospitals irrespective of the type of accommodation used. These legislative changes to allow public hospitals earn more income from privately-insured patients has had the effect of incentivising public hospitals to earn more income from patients with private insurance policies.[15]

In Ireland, private patient income accounts for 12% of total acute hospital funding.[16] Each hospital in a hospital group has two budgets: expenditure and the requirement to generate income. The HSE National Service Plan sets stretch targets, as they are termed, for income. They are only achievable if a hospital sees more private patients coming in. This places hospital management in the uncomfortable and unfortunate situation whether they are simultaneously having to advise consultants if they exceed their allowed private public ratio, while at the same time needing to maximise funding for the hospital received from private patients and their insurers.[17]

While it is the HSE which sets each hospital a target for private practice income to be generated "approval was given by the HSE, and the Minister, to promote the generation and collection of private charges income."[18]These targets therefore can be seen to incentivise hospitals to give

[13] Ms Teresa Cody, Department of Health, contribution at Joint Oireachtas Committee on Health on Wednesday 13th December 2017. Available from: http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/DebatesWebPack.nsf/committeetakes/HEJ2017121300002?opendocument#C00100

[14] Oireachtas Committee on the Future of Healthcare. (2017). Sláintecare Report. May 2017. Available from: https://www.oireachtas.ie/parliament/media/committees/futureofhealthcare/Oireachtas-Committee-on-the-Future-of-Healthcare-Slaintecare-Report-300517.pdf

[15] Burke, S. (2017). Government policy hurts public patients. The Irish Times. Available from: https://www.irishtimes.com/opinion/hospital-consultants-are-hurting-public-patients-1.3301271

[16] Liam Woods, National Director Acute Hospitals Division HSE, contribution at Joint Oireachtas Committee on Health on Wednesday 13th December 2017. Available from: http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/DebatesWebPack.nsf/committeetakes/HEJ2017121300002?opendocument#C00100

[17] Dr Peadar Gilligan, IMO, contribution at Joint Oireachtas Committee on Health on Wednesday 13th December 2017. Available from: http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/DebatesWebPack.nsf/committeetakes/HEJ2017121300002?opendocument#C00100

[18] Liam Woods, National Director Acute Hospitals Division HSE, Opening Statement at Joint Committee on Health Meeting Wednesday 13th December 2017. Available from:

preference to patients who seek care outside of the public system, but within the public hospital itself. These incentives can be seen as an inefficient allocation of public resources if it diverts these resources away from those patients that need treatment most urgently.[19]

National Treatment Purchase Fund

A further interdependence between the public and private hospital sectors, which reinforces the two-tier health system, is the National Treatment Purchase Fund (NTPF). Set up in 2002 to purchase spare capacity from the private sector (and also from public hospitals) in order to reduce the number of public patients waiting for treatment in public hospitals, it has been criticised as a vehicle perpetuating the under-resourcing of the public system.[20]

Related to how we work to remove private practice from public hospitals, as well as ensuring public resources are used for the expansion of the public system's ability to provide public care, is the question of whether we want to continue to use elective capacity within the private system on an ongoing basis or do we want to build up the public hospital system to deliver that care? While not strictly related to the provision of private practice in public hospitals, questions have been raised on whether funding the NTPF has been an efficient use of public resources and whether public hospital capacity and efficiency would have been better served with concentrated investment in enhancing that system. This would then circumvent the need to bring down waiting times by commissioning treatments form the private sector.

While use of the NTPF has had short-term impact in terms of reducing long-waiters for diagnostics, in particular, its impacts rarely last beyond the short-term, as witnessed in burgeoning waiting times across a number of areas.

The National Treatment Purchase Fund and its use by successive governments has been heavily criticised by both academics and some medical professionals for the willingness "to use public funds to pay the private sector to provide care that should be available in public hospitals, but is not, due to inadequate resourcing of the acute hospital system in Ireland.[21]

Funding

Recalling that private patient income accounts for 12% of total acute hospital funding, the issue of how to replace displaced revenue that private patients bring to the public hospital will be an important consideration. One medical professional noted that "public acute hospitals could not deliver the current level of service to the public without this revenue, let alone hope to expand or improve the clinical service that we aspire to deliver to patients.[22]

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https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_health/submissions/2017/2017-12-13_opening-statement-hse-re-consultant-contracts_en.pdf

[19] OECD/European Observatory on Health Systems and Policies (2017), Ireland: Country Health Profile 2017, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels. http://dx.doi.org/10.1787/9789264283435-en

[20] Burke, S. and Pentony, S. (2011). Eliminating Health Inequalities – A Matter of Life and Death —TASC 2011. TASC. Available from: http://hdl.handle.net/10147/301846

[21] Dr Peadar Gilligan, IMO, contribution at Joint Oireachtas Committee on Health on Wednesday 13th December 2017. Available from: http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/DebatesWebPack.nsf/committeetakes/HEJ2017121300002?opendocument#C00100

[22] Dr Tom Ryan, IHCA, contribution at Joint Oireachtas Committee on Health on Wednesday 13th December 2017. Available from: http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/DebatesWebPack.nsf/committeetakes/HEJ2017121300002?opendocument#C00100

The difficulties and drawbacks associated with removing private practice from public hospitals have been addressed in detail in the Slaintecare report. More specifically, the report recommends expanding public hospital activity and identifies mechanisms to do so, with the associated cost implications. Slaintecare proposes replacing the revenue paid to public hospitals by private insurance companies over a 5-year period from years 2 to 6 of its proposed 10 year plan[23]. Similarly, and to reflect increased demand and capacity, it allocates €119 million between years 4 and 10 to increase the numbers of consultants in public hospitals.

Legislative and Legal Issues

In addressing the legislative and legal issues that may arise, it is important to have regard to the legislative changes needed to give effect to the ten year reform package identified by the Slaintecare report.

Some potential legislation that should be considered by the Review Group, as recommended in the Slaintecare report[24], include:

- Legislate for the National Health Fund and new funding mechanisms for the transitional funding, legacy funding and package expansion components, as required
- Enact the Irish (Sláinte) Health Act which will provide the legislative basis for a universal entitlement to a broad package of health and social care for everyone living in Ireland with maximum waiting times and a Cárta Sláinte through:
    - Introducing Heads of Bill by 2017 for phased entitlement expansion to include all Irish residents by 2023

- Introducing legislation by Spring 2018 for the following waiting time policies, to be implemented on a phased basis by 2023:
    - No-one should wait more than 12 weeks for an inpatient procedure, 10 weeks for an outpatient appointment and ten days for a diagnostic test
    - Individual waiting lists are published by facility, by specialty
    - Introduce a maximum wait time in EDs, working towards a four hour target
    - Hospitals that breach guarantees are held accountable through a range of measures including sanctions on senior staff, but not to the detriment of healthcare delivery

- Legislate for national standards in clinical governance, national and local accountability structures right down to community and hospital levels, so that clinical governance covers all clinical staff including consultants

The combination of legislative changes recommended in the Slaintecare report must be considered in the review, particularly given their possible impact on dealing with unintended consequences that may arise from disentangling the two systems. Taken together, the accountability mechanisms, standards of governance, legal entitlements and the funding structures would ameliorate the demand for private provision of health services within the public system. These legislative provisions would underpin the principles of ensuring value for money, integration, oversight, accountability and correct incentives in the provision of health services.

[23] At a cost of €649 Million

[24] For the full list of proposed legislative changes see: Oireachtas Committee on the Future of Healthcare. (2017). Sláintecare Report. May 2017. Available from: https://www.oireachtas.ie/parliament/media/committees/futureofhealthcare/Oireachtas-Committee-on-the-Future-of-Healthcare-Slaintecare-Report-300517.pdf p138

Sláintecare: The Way Forward

On matters relating to current arrangements, the future direction that might apply and potential transitional arrangements as per the consultation, the Health Reform Alliance endorses the recommendations of the Sláintecare Report.

On the overarching issue of private practice in public hospitals, the Sláintecare report recommends a complete disentangling of the public and private system and provides a comprehensive blueprint for same addressing issues such as eligibility, funding, legislative issues, recruitment and retention of personnel and timeframe. The Committee on the Future of Healthcare worked painstakingly to build cross-Party consensus and engaged with stakeholders and academics in one of the greatest parliamentary exercises of our time to reform our health system. It is our belief that this report deals extensively with many of the practical issues raised by the consultation in terms of implementation, but that further work is needed with the Implementation office and the Review Group on possible unintended consequences that may not have been covered in the Report. In that regard, the impact analysis should not replace the recommendations of Sláintecare but supplement it and ensure that the aims of achieving a universal, single-tier health system are achieved.

Central to the Slaintecare report was the tenet that the delivery of private care in public hospitals works against the delivery of a single tiered universal system and, as such, the Committee on the Future of Healthcare agreed that private beds should no longer be provided in public hospitals. Recommendations of the report were therefore engineered to increase the capacity of public hospitals over time while simultaneously removing private care from public hospitals.

As part of the six critical changes highlighted to deliver a universal single tiered health system, a range of measures were identified including the replacement of private income currently received by public hospitals, and careful workforce planning and strategies to recruit and retain staff. More specifically, the report notes:

“Providing timely access to public hospital care will be achieved by the expansion of public hospital care, guaranteeing and delivering specific waiting time guarantees, and re-orientating the system so that the vast majority of care is delivered and accessible in primary and social care settings as is clinically appropriate, and by addressing under-staffing across the health system. In addition, the phased removal of private care from public hospitals alongside these measures will lead to an expansion of the public system’s ability to provide care to public patients, thereby providing universal access to public hospital care in a reasonable period of time (The time guarantees for access to public hospital care are specified in Section 3, and, under this plan, will be underpinned by legislation.)”[25]

Given the support received for the Slaintecare Report, we believe that its recommendations, timelines and costings should form the basis for the review. In that regard, and so as not to ‘reinvent the wheel’ at this critical juncture in Irish health policy, this submission endorses the recommendations made therein on acute hospital care and public-private disentanglement[26] and we would support the review group extending their impact analysis to how these recommendations could support the removal of private provision from the public system.

[25] Slaintecare Report at p66
[26] detailed on p22 of the report