Submission from Mapping the Pathways to Universal Healthcare team to the Independent Review Group examining the removal of private practice from public hospitals

Mapping the Pathways to Universal Healthcare research team

Mapping the Pathways to Universal Healthcare is a research project funded by Health Research Board running from October 2014 to October 2017. The team is led by Dr Steve Thomas, the Director of the Centre for Health Policy and Management in Trinity College Dublin. Dr Sara Burke is the project co-ordinator and other team members are Dr Sarah Barry, Dr Bridget Johnston, Maebh Ní Fhallúin and Rikke Siersbaek.

Building on our prior work for the HRB funded, three-year Resilience research project [1], the Pathways project is mapping a potential pathway or pathways to universal healthcare through the three components of the research project:

- Assessing the gap between current Irish health system performance and universal healthcare, using and adapting World Health Organisation concepts;
- Evaluating the strengths and weaknesses of different models of universal healthcare and assessing their feasibility of implementation within the current context according to key criteria such as affordability, human resources and complexity of design;
- Assessing the organisational challenges of moving to universal healthcare by reviewing the experience of other countries and exploring the current capacity and constraints facing decision makers throughout the system [2].

Research carried out by the Pathways team has demonstrated the unequal nature of the Irish health system that privileges private patients over public patients and discriminates on the basis of ability to pay [3-5]. A critical aspect of the inequality that exists in the Irish health system is the provision of private care in public hospitals and the fact that private patients can gain faster access to diagnosis and care, even within the public hospital system [5].

For six months from November 2016 to May 2017, the Pathways team worked with the Oireachtas Committee on the Future of Healthcare, providing technical advice and expertise to the Committee and assisting with drafting the Committee's report, known as Sláintecare [6].

Context

A key recommendation in Sláintecare is the expansion of public activity in public hospitals and the removal of private care in public hospitals. This was phased between years two and six of the plan, in recognition of the fact that a measure like this cannot happen overnight. The Committee also recommended 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' [6].

The terms of reference of the Committee specified the need to establish a universal single tier service where patients are treated on the basis of health need rather than on ability to pay *[6].*

Early in our work with the Committee in November and December 2016, the Committee agreed eight principles under three key themes which framed and underpinned its recommendations. These included

- *Timely access to all health and social care according to medical need*
- *Care provided free at point of delivery, based entirely on clinical need*
- *Patients accessing care at most appropriate, cost effective service level with a strong emphasis on prevention and public health*
- *The health service workforce is appropriate, accountable, flexible, well-resourced, supported and valued*
- *Public money is only spent in the public interest/for the public good (ensuring value for money, integration, oversight, accountability and correct incentives)*
- *Accountability, effective organisational alignment and good governance are central to the organisation and functioning of the health system [6].*

A key component of the Entitlement and Access section of the Sláintecare report is 'providing timely access to public hospital care… by a series of measures including… the phased elimination of private care from public hospitals, leading to an expansion of the public system's ability to provide private care' [6].

Six critical changes were identified as central to the delivery of efficient, effective and integrated care in Sláintecare including

> *The disentanglement of public and private care and the phased elimination of private care from public hospitals. This will require a range of measures including, addressing the replacement of private income currently received by public hospitals, and careful workforce planning and strategies to recruit and retain staff. As noted above, the Committee recommends an independent impact analysis of the separation of private practice from the public system with a view to identifying any adverse and unintended consequences that may arise for the public system in the separation [6].*

Key issues for the Independent Review Group examining the removal of private practice from public hospitals

This submission briefly outlines the team's analysis under each terms of reference of the Group:

The existing nature, level and role of private practice in public hospitals

The HSE publishes national and hospital level figures on the extent of private inpatient and day case discharges. Most recent figures publicly available for September 2017, show 82% of all inpatient hospital discharges are public patients, while 85.8% of day case discharges are public patients [7]. These are above the 80:20 public private mix as specified in the 2008 consultants' contract and in government health policy which specified a maximum of 20% private work in public hospitals. A Department of Health publication found that between 2012 and 2016, elective inpatient discharges were 73% public, 27% private [8].

However, these high level national and hospital figures mask the extent of private work in some specialities in public hospitals as they include all emergency admissions, which are largely public discharges – the vast majority of all public hospital discharges are patients admitted through the Emergency Department. In 2016, the last full year of publicly available data, 83% of all (non-maternity) public hospital inpatient discharges were from emergency admissions [9].

The global figures also fail to show activities at specialty and consultant level for elective care. Figures released to RTE Investigates Programme shown on 21 November 2017 proved that some consultants work way beyond their designated private workload in public hospitals. Such figures are gathered by hospitals and hospital groups but are no longer collected nationally by the HSE since a change in bed designation in 2014. Since 2014, there is no longer a stipulation of 80:20% public private mix for public hospitals, although Section 20 in the 2008 Consultants Contract still applies, giving a 0%, 20% or 30% private work for consultants working in public hospitals depending on their contract type [10].

As consultants and hospitals are paid a fee for every private patient seen and a capitation grant for all public patients, no matter how many or few they treat, the economic incentive in the system is to treat private patients. Also, as demonstrated by RTE Investigates Programme on 21 November 2017, some consultants also work off site even though this is not stipulated for in their contract. Public hospitals' financial dependency on private insurance income results in poorer access and quality of care for public patients who have to wait longer for care and receive less consultant-provided care as consultants are caring for private patients on or off site.

The negative and positive aspects of private practice in public hospitals, as regards access to healthcare, equity and the operation of public hospitals

Disentangling and removing private care from public hospitals is essential to delivering universal healthcare in Ireland. The existence of private care in public hospitals institutionalises inequity in the Irish public hospital system. It means that people who can afford to pay privately or who have private health insurance can gain access to faster care in the public hospital system. This is particularly the case for access to outpatient appointments and elective care in public hospitals. Generally, those who present at Emergency Departments are treated solely on the basis of medical need, ie it is the one part of the public hospital system where money does not allow you to skip the queue.

But if one can afford to pay privately, one can go see a consultant as a private outpatient, often in rooms on site in the public hospital or off site beside the public hospital and then can be referred into the public hospital for care, where the same consultant may also work. This allows people to skip the often long-waits for public outpatient appointments. In December 2017, there were 350,192 people waiting over three months for their first public outpatient appointment, of these 138,058 were waiting more than a year [11]. Also if seen as a public patient and referred for elective care, if there is a long wait publicly, patients can be treated as a private patient in the public hospital, again skipping the queue where public patients wait for care. In December 2017, there were 52,542 people waiting over three months for public inpatient and day case care, of these 13,385 were waiting longer than a year [12].

Although in theory there is a 'common waiting' list for treatment in Irish public hospitals, the incentives in place and the embedded nature of the public and private mix means in effect private patients are often privileged over public ones within the public hospital system. For example, one is more likely to be seen by a consultant if one is a private patient and more likely to be treated by a more junior doctor if a public patient.

While consultants are paid a fee for each private patient seen in a public hospitals and hospitals are paid a set rate per night for treatment, there is no data to determine if the total cost of private care in public hospitals is covered fully by private fees. There is only data available to quantify the actual income received by hospitals from private insurance companies. There is no public record of the private income of publicly paid consultants working in public hospitals. Neither is there any tracking of whether consultants meet their public hospital work commitments under the 2008 contract. In December 2017, senior Department of Health officials acknowledged the absence of compliance with contracts and the failure of the HSE to effectively monitor and enforce compliance [13].

What practical approaches might be taken to the removal of private practice from public hospitals, including timeframe and phasing

The logic behind the phased approach taken in Sláintecare to remove private care from public hospitals over a five year period from year two of the plan is that it will take time and money to disentangle current practice, recognising the historical and embedded nature of two tier public hospital care in Ireland.

According to the most recent publicly available HSE figures, public hospitals received €652.7 million in income from private insurance companies in 2016 [9]. Two different figures appear in the Sláintecare report for this – €649 million which was the projection for income for 2016 given to the Pathways team when the Oireachtas Committee was drafting its report. This figure was used in the costings. Another lower figure of €629 million is also cited in the report which came from the Oireachtas team working with the Committee. The figure €652 million is the actual figure for 2016 which became available after the work of the Committee was complete.

Replacing the private income in public hospitals will allow public hospitals to provide more care for public patients, removing the perverse incentives and discrimination that results from the current system. Due to the time constraints of our work with the Oireachtas Committee and the limited or non-existent data and information on private care in public hospitals, it was not possible to cost the entire costs to the public system. For example, the above figure does not include tax relief for private health insurance, medical indemnity of consultants practising publicly and privately or the actual cost beyond the consultants' fee and rate paid to the hospitals of providing private care in public hospitals.

Revenue publish figures on tax reliefs which show that in the most recent year available €325.2 million was given in tax reliefs for medical (ie private health) insurance. Since 2004, when data was first collated on this €4.494 billion has been given in tax reliefs for medical insurance [14]. If Ireland was to choose to fund a purely public system, stopping paying tax reliefs for medical insurance could result in significant additional resources available for the public system.

Possible impacts, both direct and indirect, immediate and over time, of removing private practice from public hospitals, including but not limited to impacts on: access; hospital activity (including specialist services); funding; recruitment and retention of personnel; and any legal or legislative issues that might arise

Sláintecare outlines how all elements of the report are interconnected and need to be implemented in a coherent manner. For example under the 'public hospital activity expansion' the following is cited

Introduce a range of measures to undo two tier access to public hospital care including:

- *Increased access to diagnostics in the community*
- *Reduced waiting lists for first outpatient department (OPD) appointment and hospital treatment, and*
- *Expand public hospital capacity.*

The first two of these must be progressively realised in the early years of the plan. The removal of private care in public hospitals will require time to phase out. Increasing public hospital capacity will partially be achieved by freeing up existing capacity by, amongst other measures, transferring care from hospitals to the community, and phasing out private care in public hospitals. This will require:

- *Increased public funding to replace current private income in public hospitals;*
- *New governance structures to ensure quality care and accountability;*
- *Changes to incentives and work contracts;*
- *Alongside precise workforce planning to ensure the public system is an attractive place to work for staff who deliver high quality care;*
- *The hospital sector will also need increased capacity in areas where it is currently under-resourced P 59 [6].*

These combined measures will result in better access to diagnosis, treatment and care for all Irish citizens. It will also result in a significant shift of care from hospitals to the community, so where possible timely access to diagnostics in the community, the provision and management of chronic diseases in the community which in turn frees up hospitals to care for public patients who need acute, specialist or emergency care.

Currently, the Irish health system is over reliant on the hospital system and public hospitals are operating beyond full capacity. There will need to be public funding increases to replace private insurance income and to meet the population's acute health needs but this increased acute funding must be aligned with a significant expansion of funding for public health, primary and community services so that an integrated health system can be realised.

Investing in and improving access and the quality of care of the public hospital and health system will make it a more attractive place to work. Given the difficulties with recruitment and retention at the moment, it is imperative that these are not worsened by such a measure. While Sláintecare specifies the ending of private care in public hospitals, it does not rule out consultants working part time in private standalone hospitals as well as fulfilling their public work. In order for this to be realised, there will need to be effective monitoring of consultants' workload in public hospitals, as well as the introduction of governance and accountability measures.

Disentangling private care from public hospitals will require a change in the 2008 Consultants' Contract. It may also require legislation or an amendment to health acts to designate all pubic hospital beds are for public patients.

This submission was drafted by Dr Sara Burke, co-ordinator of the Pathways to Universal Healthcare team, if you would like more information on any of the content, the team (Prof Steve Thomas, Dr Sara Burke, Dr Sarah Barry, Dr Bridget Johnston, Rikke Siersbaek, Maebh Ní Fhallúin) would welcome the opportunity to respond to any queries or to meet with the review group.

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