Consultation on Private Practice in Public Hospitals

A submission to the Independent Review Group from the Adelaide Health Foundation

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In this submission, we focus primarily on the first theme in the Open Consultation document- eligibility, access and equity.

Context: The Adelaide Health Foundation strongly endorses one of the key principles of the Slaintecare report[1], namely-

- *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*

Ireland is unique within Europe in having (a) the highest rate of double insurance (taxation plus private health insurance), combined with (b) the worst access to healthcare for public patients in Europe[2].

Eligibility, access and equity: Successive Governments and Ministries of Health have found themselves unable to deliver on the recommendations of health reports over many decades recommending equity of care and equal access to services. Within Europe, health outcomes relate to wealth, as measured by gross domestic product, but access to services is not related to wealth[2]. Thus, the issue of access is likely to be one of organisational and managerial efficiency and not just related to insufficient resources. It has been shown that

waiting lists do not to contain costs. Waiting for medical care substantially increases health costs as patients become sicker and ultimately require more complex and expensive care. Waiting times for procedures, including investigations, are not evenly distributed, with public patients waiting longer than private patients. The AHF strongly believes that healthcare reform should bring about a level playing field between the private and public systems. The current two-tier system has been shown to be ineffective for all groups, GMS and private, with GMS patients facing long waiting times and private patients' high insurance premiums.

The high level of private insurance in Ireland relates directly to the difficulties in accessing services, be they diagnostic or therapeutic. Private waiting lists are kept separate from public ones essentially to enable quicker access to services for those who are privately insured. It is therefore natural to wish to remove private care from public hospitals, both to release needed beds and to avoid queue jumping.

The AHF supports the Slaintecare recommendation to encourage removal of private healthcare from the public system and also agrees that the mechanism and possible consequences deserve debate. One would wish for an equitable healthcare system that renders private care unnecessary. But the question arises as to whether separating private from public care might merely serve to entrench the current two-tier system of care. Requiring consultants to work in one or other system with no cross-cover may not result in maximising either efficiency or equity.

There may be a mis-perception that private hospitals provide better medical care. There is no evidence for this (apart from speedy access) and indeed it is highly unlikely that they can provide better care than a public teaching hospital, with the latter's availability of multiple accredited specialists and high-grade doctors in training.

The countries in Europe that score highest in terms of the quality of their healthcare services are mostly Central and Northern European[2]. While there are funding and organisational differences, virtually all have adopted a form of Universal Health Care (UHC). At least in larger countries, competitive insurance-based systems with purchaser-provider separation appear to perform better, whereas a single payer model may work adequately well in, for example, smaller but well-organised Scandinavian countries with a strong commitment to social equality and solidarity.

The Adelaide Health Foundation (AHF) has vigorously promoted the concept of Universal Health Care and has supported this with evidence based expert monographs. Further monographs written by the AHF explore integrated care and chronic disease management. All are available through the AHF website[3]. Recent research commissioned by the AHF has examined, for the first time, the Irish peoples' opinion of UHC[4]. The introduction of UHC in Ireland was supported by 87.0% (n = 846) of participants. Factors determining support for UHC were defined.

Slaintecare[1] appears to promote an equal, Universal Health Care approach in General Practice and in Primary care but appears not to be so committed to this principle in proposals for the delivery of hospital care. The full implementation of UHC in hospital care

would imply equal treatment for both public and privately insured patients. This in turn would imply the need for a single waiting list. The only benefit of private insurance might be in terms of accommodation and perhaps catering. By the same token public patients might equally be accommodated in private hospitals.

Implicit in this is the need to examine the incentives that may make consultants give more time to private patients in public hospitals, and to neutralise such incentives, as well as using peer-review monitoring of work practices. But better to have a consultant on-site than working also in a separate private hospital at a separate location. Evidence of benefit of requiring a consultant to be either 100% public or private is not, to our knowledge, available.

Several countries with limited resources including, for example, Macedonia, appear to have radically improved waiting times by introducing an open-access, electronic booking system for investigative and clinical services. Patients can decide where they wish to receive care and may for example, choose to travel to avail of rapid access to services. While the AHF strongly endorses the development of Primary Care and General Practice, experience from other countries provides less than promising evidence that using good primary care as a "gate-keeper" to hospital care does much to reduce waiting times or improve efficiency.

Reducing the inequities between the public and private sector may meet with opposition, especially from the private sector which benefits from long public waiting lists. In our opinion, introducing a single waiting list system for all patients, regardless of public or private health insurance, is the most efficient way of promoting equal access to healthcare services. There may well be other overt, covert or inadvertent impediments to these suggestions but they are indisputably fair and a single waiting list system would be easier to regulate than interventions at multiple levels. Resources could then be directed at monitoring this single intervention.

It is hard for the AHF to see the logic of purchasing services from the private sector, as in the Treatment-Purchase Fund proposal, as opposed to investing in better public services. Public hospitals exist to treat patients. Private hospitals treat patients but their raison d'etre is to make money. It seems that purchasing from the private services is boosting private enterprise rather than using the private system to improve the public health care system. This enhances the profit of the private sector at the cost of the public system.

The Adelaide Health Foundation would therefore advise consideration of the following:

1. Extend the progressive adoption of the principles of Universal Health Care to Irish Hospitals.

2. Use this to progressively reduce the differences and inequities between the public and private sector.

3. Introduce a mandatory single waiting list system for public and private patients.

4. Consider an open, electronic single appointment system for investigations and treatment throughout Ireland and to ensure that this is monitored without prejudice.

5. Commission a forensic stakeholder analysis to identify overt, covert and inadvertent blocks to healthcare reform, particularly regarding the inequities between public and private care

6. Commission an objective review of the logic and financial aspects of purchasing services from the private sector.

References:

1. Houses of the Oireachtas Committee on the Future of Healthcare Sláintecare Report May 2017

2. Health Consumer Powerhouse. Euro Health Consumer Index 2017. https://healthpowerhouse.com/

3. All reports available through www.adelaide.ie See "Health Policy" and then "Health Research Reports and other publications"

4. Darker, CD., Donnelly-Swift, Whiston (in press)., Demographic factors and attitudes that influence the support of the general public for the introduction of universal healthcare in Ireland: A national survey, *Health Policy,* http://www.healthpolicyjrnl.com/article/S0168-8510(17)30321-4/fulltext