Re: Private Practice in Public Hospitals
John Barton
to:
IRGPrivatePublic
09/02/2018 19:27
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1 Attachment

Private Practice in Public Hospitals (2).docx

Dear Sir/Madam,

I would appreciate if you would use this spell checked final draft of my submission sent earlier just before 5pm.

Again I would like to know that this submission is read by members of the committee, as my last submission to the Oireachtas Committee on the future of health care in 2016 was not read or reviewed by either the Chairperson or at the very least the Fine Gael members of the committee. I do not understand a situation, when members of the public spend time researching and preparing a document for a committee set up by Government or the Dail do not read the documents.

I do hope that my submission is read by la member or members of the committee.

I would appreciate if this spell checked draft is the document that is given to the committee.

I would also appreciate acknowledgement of receipt of my submission.

Dr John Barton

Private Practice in Public Hospitals.
A submission by Dr John Barton

Retired Physician/Cardiologist Portiuncula Hospital
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Equitable Access to Health Care.

Ireland has a two tier system in access to hospital care and it is this two tier system that politicians and many health and social care professionals would like to see removed. I strongly believe that the definition of the two tier system in Slainte care is too restrictive, in that it is concerned with the two tier system in public hospitals. The inequity in access to hospital care is increasingly been accentuated by the increasing provision of health services by private sector hospitals with more and more members of the public using these hospitals in order to acquire quicker access to hospital treatment and better facilities. The inequity in access to hospital care, the two tier system, has shifted substantially to private hospitals and is not solely the domain of public hospitals.

Professor Eddy van Doorslaer and colleague researchers in the Health Equity Research Group of the OECD published a study in 2004 on income related inequality in access to health care[1]. Ireland was found to have the third most inequitable hospital system in respect of access to hospital care, with the two other countries worse than Ireland been Finland and Portugal. The study found that we had a pro rich bias in access to hospital care, while our primary care service was pro poor. Professor van Doorslaer analysed the reasons for this inequitable access to hospital care across the 21 countries studied, and found that in Ireland, the most important reason for the inequity in access to hospital care was private health insurance (PHI). One of the reasons that PHI drives inequity is that it provides consultants in certain specialties with fees per item and therefore, income markedly in excess of their public salaries. The financial incentives to treat patients are entirely in the direction of the private patient. Without addressing this fundamental driver of inequity, it will be difficult to achieve equitable access to health care, one of the fundamental principles espoused in Slainte care and a key principle of Universal Health Care. As long as Ireland retains a parallel private hospital system funded by supplementary PHI, inequity will persist and equitable access will not be achieved. The UK has an NHS but around 10% of the population has voluntary PHI, and this provides patients with quicker access to private treatment in the private sector. Any system with a parallel private system funded by supplementary PHI, as opposed to complementary PHI, such as in France, delivers inequity in access to health care. Professor van Doorslaer and the Health Equity Research Group have found similar inequity in the Australian health care system in their study in that country.[2]

The chairperson of the Oireachtas committee on the future of health care, Roisin Shortall, truly hopes that by developing a strong public health and hospital system, the people of Ireland will forego their PHI. I would be concerned about the unintended consequences of that reality for the private hospital sector.

The proposal by our politicians in Slainte care to remove all private practice in public hospitals and create a single tier system has not been sufficiently thought through. The two tier system of access to hospital care and the main driver of this PHI, will remain in place. I appreciate that politically, one could not remove PHI from the system, and even the modest proposal to cease the tax subsidisation

of PHI in an earlier draft of the Slainte care proposals had to be removed from the final draft, for political reasons.

There are other reasons for inequity such as incomplete coverage of populations for access to health care, and wealthier people are able to access health care more quickly than poorer people as shown in Canada in a study carried out in Winnipeg, Manitoba. Canada has a universal public health insurance system and does not allow by law, private health insurance for hospital services provided in the public system. But despite the Canadians having equity of access to health care enshrined in law through the Canada Health Act, inequity of access to health care occurs for other reasons.

PRIVATE PRACTICE IN PUBLIC HOSPITALS.

It is likely that most private practise in public hospitals is generated by patients with PHI being admitted acutely to public hospitals, particularly in situations where there are no private hospitals in proximity to a public hospital, which would occur more frequently in rural settings. Since the development of the private hospital sector particularly in our cities of Dublin, Cork and Galway, access for acute care services is available in the private hospitals from 08.00am to 8pm. In the Mater Private Hospital, there is now access to acute cardiology services 24 hours a day. Increasing day case and elective procedures are being carried out at private hospitals.[3]

The one city without a significant Private Hospital is Limerick, and the recent Prime Time Investigates programme on consultants abusing their contract highlighted the inequity of access to a public orthopaedic hospital, in all likelihood, driven by the PHI coverage of patients with such problems. There is no private hospital in Limerick providing orthopaedic care and yet it is likely a substantial population of people in the Limerick area have PHI and wish to have their care locally, closest to home as possible.

Where there are no private hospitals providing acute care services close to a public hospital, the situation applying for most rural hospitals, including the hospital I worked in, Portiuncula in Ballinasloe, up to the time of the development of the Galway Clinic, most patients with PHI needing acute care came to Portiuncula, with patients in the Longford Westmeath area going to Mullingar and those in the Offaly catchment going for instance to Tullamore. Much of my private practise was driven by emergency admissions to the hospital through the A&E department. I had no control over that aspect of my private practise. Since the development of the Galway Clinic A&E service, more and more patients are now being sent to that hospital, as individuals and General Practitioners are choosing that hospital and GPs are sending their patients there, so as to avoid waits in A&E at the public hospital and having to suffer the possible indignity of the well-publicised trolley crises in our public hospitals, but also because their patients would initially get a consultant delivered service as opposed to an Non Consultant Hospital doctor delivered service at the local public hospital. If patients needed ambulance transfer to a hospital because of the acuity of their illness, then in most instances those patients are brought to the nearest public hospital. So, for the population of Athlone and its environs for instance, those patients would be admitted to Portiuncula and of course that cohort of patients would include patients with PHI. Those patients becoming ill after 8pm and before 08.00 am would also be transferred to Portiuncula.

It is true that if GPs were happy with a consultants care of their public and private patents that those GPs would then refer non acute patients to that same consultant. So, in my own case, I had a rooms

practice, initially twice weekly, cutting down 15 years ago to one clinic a week, seeing on average 6 to 7 patients weekly.

I have been a strong believer in the concept of Universal Health Care with care based on need and not on income. The two-tier system and the vagaries of our dysfunctional and underfunded public hospital system has disgusted me for many years, so much so, that I took an interest in politics as I saw the solution to our health care crisis had to be through the political system and political leadership. The way that I envisaged that being achieved in Ireland was through a Universal Health Insurance system, based on the fact that the two-tier system was driven by PHI. Because of my involvement in the political process, I researched health insurance, as a result of which, the Fine Gael party and its health spokesperson and subsequently, Minister for Health, James Reilly, proposed such a system, the health insurance for all concept, based on the fact that the main driver of the inequitable two tier system in Ireland is our voluntary supplementary PHI system. For political reasons, the recession, and because of inaccurate assumptions of PHI companies margins in an ESRI report on the government's proposals in November 2015, the concept was dropped by the last Minister for Health, Leo Varadkar.

A window of opportunity for cross party agreement on health care subsequently arose as a result of the large interregnum period before the current government was formed and the result of this has been the Slainte Care Report, which recommends the removal of private practise in public hospitals.

I cannot find any reference to academic publications in the report in regard to dual practise in health care. During my work on health insurance I did come across some academic articles in the literature on this subject, and remember that such papers did not recommend the removal of private practise in public hospitals. I encourage all members of the group to read a paper published in an academic journal I have been purchasing for many years now, and the only one of its kind I believe, the Journal of Health Politics, Policy and Law.[4] The article is written by Ariadna Garcia-Prado, PhD in Economics, who works at the Department of Economics University of Navarra and for the Inter-American Development Bank, and Professor Paula Gonzalez PhD, of the Univerisity Pablo de Olavide in Seville, an economist at the university, with an interest in health economics research. They did an extensive literature review of the papers on dual practise in health care both in developing and developed countries. Their summary in respect of higher income developed countries was that there should be limiting policies regarding private practice but in the context of the development of private practice in public facilities. The authors at one point in their paper state that they do not believe that banning dual practice is a good strategy and follow this by saying that professional self-regulation is very strong and may act as deterrent for the undesirable behaviours associated with dual practise. Unfortunately, the system of regulation in Ireland has failed to control the minority of consultants who do private practice off site in private facilities as highlighted by the Prime Time Investigates programme on this issue.

There is frequent reference in Ireland by politicians and policy makers to this country as being an outlier in regard to private practice in public facilities but the authors of this paper refer to countries where there is a policy of encouraging doctors to develop their private practices within "government" hospitals, and in terms of regulation, recommend that hospital administration collects private fees, and physicians receive payment adjusted for the use of hospital facilities and equipment. They state that such policies have been pursued in France, Austria, Germany, Ireland and Italy. In respect of limiting policy, they refer to a limiting policy in respect of the amount of income generated from private practice, and the second policy, is for government to set a maximum

quantity of services that can be performed in the private sector. These authors recommend the latter limiting policy. This has been the policy in the Irish public hospital sector but I believe personally that the administration of this has been weak. The authors refer to the offering of exclusive public only contracts, which only 9% of consultants do here, and they state that these would only be effective in the context of the financial remuneration being enough to compensate for the losses of not working in the private sector. In Austria for instance, senior doctors earn more than two times their public salary in the private sector, so the strategy of enhancing the public salary to the level commensurate with private income is considered too costly. I have absolutely no doubt that certain consultants in Ireland in the orthopaedic, vascular, cardiac, gastroenterology and other specialties where procedures are performed including surgical specialties would earn income three and more times their public salaries. We are aware from the semi-state VHI of one consultant who earned a million euros in VHI payments some years ago.

The authors do refer to some governments offering other allowances or other work benefits to physicians who work exclusively for public hospitals and clinics. I have not worked in the NHS in England, where 60% of consultants also work in the private sector, but colleagues of mine who trained in the NHS and were consultants there, do refer to other income incentives in the NHS that may include teaching, or quality incentives. I expect you may receive other submissions, which may highlight these. Two colleagues of mine from Canada, where the universal health insurance (UHI) system is a public system, are given benefits such as sabbaticals abroad to do research, teaching or further training in procedures every 5 to 7 years. There is minimal dual practise in the United States.

In another paper on the issue of dual practice, titled "Implications of Dual Practice for Universal Health Coverage, published in the Bulletin of the World Health Organisation in 2016, the authors from several institutions, the Nossal Institute for Global Health at the University of Melbourne, the Instituto de Higiene e Medicina Tropical, Nova University of Lisbon, UNICEF, and the World Health Organisation itself, do a relatively short summary of dual practice in developing and developed countries. They recommend for high – income countries with sophisticated health systems, established private sectors, strong and independent regulatory capacity and empowered patient advocacy groups, that the regulatory efforts should be aimed at helping the market enhance breadth and quality of available services, as well as retaining health personnel in the public sector. The options include 1. Regulating public – private partnerships, 2. Building positive incentives into contracts to outsource public services and 3. Giving professional councils a primary role in defining the boundaries of dual practice. My own personal opinion is that there may be a case that the Royal Colleges of Surgeons or Physicians in Ireland might take a role in this regard or indeed this is a role that may be appropriate for the Medical Council who regulate the medical profession in terms of standards of practise to acquire. This would require investment in better data collection and analysis, and the authors of the paper recommend this as a prerequisite to designing and monitoring appropriate regulation of dual practise. Given the increasing role of consultants as national clinical directors, it may be possible for the HSE to regulate such practise centrally. The alternative is to have a specific group/committe within the local/regional clinical directorates who would deal with this issue. It is more difficult for local regulation because of the personal relationships that consultants have within a particular hospital and therefore my suggestion to have this done on a regional basis. The authors do not go into detail about these options given the relative brevity of the paper but there are references to all three options, one of which is a paper referring to the motivation and values of hospital consultants in south east England who work in the National Health Service (NHS) and also do private practice. I will review this paper and can forward my comments at a later date. The self-regulating mechanism on private practise here to monitor the 80/20 split in private practice

in public hospitals has clearly failed. None the less, and to be fair to many if not most consultants working in public hospitals, the 20% private portion of the contract could well be exceeded by the fact that insured patients are presenting to the hospital by virtue of the acuity of their condition, requiring ambulance transfer to the hospital. This issue is likely to be more significant in public hospitals where there is no private hospital nearby, as mentioned previously.

The Private Practice in Public hospitals committee set up by government is looking for suggestions as to ending private practise in public hospitals. Neither of the papers referred to above recommends this but the papers do refer to possible options such as increases in salary and other income increasing benefits. I believe we should consider additional financial incentives for hospitals, attached to the delivery of quality health care. Such financial systems are in place in the US. Those physicians delivering this care could then be rewarded for their efforts by the hospital.

It is my view that the proposal to remove private practise in public hospitals may have a detrimental effect on public hospitals in particular, in respect of the objective of having care as close to home as possible. So, for example in the case of Portiuncula, privately insured patients in Athlone will no longer be investigated or treated at Portiuncula, unless they are admitted acutely and then they will be cared for as public patients. But with the increasing trend for day case treatments, such elective care will have to take place at a more remote location, and for older patients who do not like travel, this will be an issue. This situation would be worse for patients in Donegal or Cavan/Monagahan where there are no private hospital facilities.

There is a risk of an increasing flow of consultants moving from the public system to the private system, as suggested in the papers referenced above. This has already been ongoing and has affected Portiuncula hospital when I worked there with a colleague who left for the Private sector. The consultant cardiologist who replaced me at Portiuncula came back from the United States after six years in the States, to take up the job at Portiuncula. The job was structured in a way that the cardiologist does no on call service and so he receives admissions through the A&E department. His private practice is therefore predominantly elective outpatient work and indeed he is increasingly busy in this regard. The removal of private practice rights I believe would trigger a move to the private sector or back to the United States, despite his desire to remain in Ireland and bring up his children in Galway. A recent event at Portiuncula, non-financial, gave rise to his consideration of a move to the private sector here or a return to the US. I am also aware of a radiologist who left University Hospital Galway to work in the Galway Clinic and a number of consultant orthopaedic surgeons who have done so in Dublin. A colleague cardiologist has just left St Vincents Hospital for the Blackrock Clinic.

It is important to highlight that remuneration is not the main reason why consultants leave the public sector. A review by the Canadian Foundation for Health Care Improvement, "Myth: Doctors do it for money" is in keeping with this belief.

REFERENCES

Van Doorslaer E, Koolman X, Jones AM. Explaining Income-Related Inequalities in Doctor Utilisation in Europe: Health Economics 2004:13; 629-647.

Van Doorslaer E, Clarke P, Savage E, Hall J. Horizontal Inequities in Australia's Mixed Public/Private Health Care System. Health Policy 2008: 86; 97-108.

Maev – Ann Wren, et al. ESRI: Projections of Demand for Health Care in Ireland, 2015-2030: First Report from the Hippocrates Model.

Ariadna Garcia-Prado, Paula Gonzalez: Journal of Health Politics, and Law 2011; 36, 2: 265 – 294.

Barbra Mc Pake et al. Implications of Dual Practice for Universal Health Coverage. Bulletin of the World Health Organisation 2016; 94: 142-146