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Addressing the Health Care Crisis



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Irish Congress of Trade Unions





Note

This report was researched and written by Sara Burke and produced jointly by the Irish Congress of Trade Unions and Siptu. It draws heavily on *How Ireland Cares, the Case for Health Care Reform* by A. Dale Tussing and Maev-Ann Wren (New Island, 2006), which itself was the result of a study Congress had commissioned the authors to carry out, in advance of the opening of new social partnership talks. Where possible, statistics have been updated since the publication of *How Ireland Cares*.

Executive Summary

The Problems

Spending

It is a fact that health spending has increased in recent years and that current spending is almost three times what it was a decade ago, in 1997.

Presented in isolation, this stark fact appears to support the oft-repeated allegation that there is a 'black hole' at the heart of our health system, into which vast and ever increasing amounts of money simply disappear every year.

Dramatic though it may sound, this allegation is actually untrue. But unfortunately, the myth of the 'black hole' has gained some credence and is employed frequently by critics of the public health system and advocates of 'for profit' private care.

Focussing solely on the increased health budget and citing it in isolation results in key facts being obscured and hampers understanding of the real causes of the crisis in our health system.

Our increased health spending is actually a new and recent phenomenon. Indeed, it is only now that we are beginning to undo some of the damage done to the health service by decades of chronic under spending and cutbacks.

It is also important to understand that Ireland still includes some 'social spending' in our health budget, thereby distorting the size of that budget. In international comparisons, most other countries separate out the money spent on areas like care for older people and people with disabilities. By not doing so, we artificially inflate the size of our health budget.

Furthermore, the health care sector is not immune to inflation. Each year, the cost of equipment, drugs and other supplies tend to

rise. The health services are not immune to rising prices and each annual health budget must take account of these increases. Equally, our population has experienced dramatic growth in recent years, with the Census 2006 findings showing a figure in excess of 4.2 million, up from 3.6 million in 1996. More people naturally places greater demands on existing services.

Beds

In 2002, the previous coalition Government promised 3,000 extra hospital beds. They have not been delivered. In fact, just a fraction of that number has actually materialised. Without those new beds, we cannot begin to undo the damage done by health cutbacks of the 1980s, when beds were stripped from the system, let alone build the sort of world class public health service which this country both needs and deserves.

Equal Access

Our health system is unequal. Those who can afford to pay will quickly access consultant-provided hospital care. Those who cannot pay will typically wait longer to access care provided by overworked junior doctors.

Currently the treatment of private patients in public hospitals is subsidised by the taxpayer, while private healthcare receives financial incentives from government in the form of generous tax breaks and in how doctors and hospitals are actually paid.

In addition, plans to construct private hospitals on the grounds of public facilities are well-advanced. This could see the taxpayer shell out in excess of €100 million in tax breaks, for facilities that will be entirely private and owned solely by investors. This huge subsidy to private healthcare is a wasteful use of public money and will further entrench inequality in our health system.

These commitments have not been delivered on.

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General Practitioner (GP) Care

In most EU countries people access GP and community health services at no cost or very low cost. But in Ireland 70 percent of the population pay a fee each time they visit a GP. Primary, community and continuing care services are seriously underdeveloped, while some essential services like physiotherapy, speech and language therapy either do not exist or have long waiting times. Care for older people is being privatised at a huge cost to patients and the public health system.

The Solution

Investing in equality

Ireland both needs and deserves a high-quality healthcare system – the fabled “world class system” that has been repeatedly promised and never delivered. Ireland now has among the highest income per capita in the EU and the public finances are strong. A world class health service is both affordable and achievable. At its core must be the principle that care is provided on the basis of need, not the ability to pay.

The investment needs of the service were listed in the 2001 Health Strategy Quality & Fairness, A Health System for You, - a blueprint supported by the 2002-2007 coalition, but which remains unimplemented.

Meeting the targets outlined in the Health Strategy would require a doubling of investment in healthcare facilities (hospitals, clinics etc) over the next decade and a 10 percent increase in day-to-day spending on health.

This is a substantial amount of money, but it would still be significantly lower than what we spend on roads and transport. Our health service deserves at least equal priority.

We need some 400 additional new public hospital beds, every year up to 2013 (the same lifespan as the NDP). Naturally, additional doctors, nurses and other front line staff will be required to ensure the new beds are fully utilised.

To ensure equality of access we need a common waiting list for all patients and an end to designating patients as public or private, within all public facilities. Public money should be invested solely in public facilities, to create a one-tier public health service. Taxpayers should not be forced to subsidise private investment in private healthcare.

Doctors and hospitals must be paid in the same way for treating both private and public patients, as the current system incentivises treatment of private patients.

Introduction

The Record so Far

In 2002, Fianna Fáil and the Progressive Democrats based their election campaign - that part relating to health - on the 2001 Health Strategy. Their commitments included:

- 3,000 more beds in hospitals, 2,800 of which were to be inpatient beds
- 5,600 extended care/community nursing beds for older people delivered over 7 years
- An end to waiting times longer than three months for surgical or medical treatment in hospital by the end of 2004
- A new model of primary care which would provide a new modern multi-disciplinary team based primary care service rolled out across the country as a priority
- Increased staffing for the health services
- Health care provided on the basis of need, not ability to pay

These commitments have not been delivered on.

Hospital beds The most recent available figures show that by the end of 2005, just 724 additional in-patient beds had been delivered, a spectacular 2276 beds short of what was promised. Recent population increases mean the shortfall is all the more damaging.

Community nursing beds for older people

By the end of 2004, 500 new public beds and 1,300 additional private beds were in place, a

total of 1,800. But as the majority are private beds they cannot provide the care needed by many older people (see section *Long Term Care for Older People*).

Waiting lists Many public patients still have to wait far longer than three months to commence treatment. In December 2006, some 15,096 adults were waiting for surgical procedures and 4,425 were awaiting medical procedures. Of these, 69 percent of adults were waiting over six months for surgical procedures and 66 percent were waiting over six months for medical procedures. This does not include the time spent waiting to get referral and so is an understatement of actual waiting times.

Primary care Ten pilot teams were selected in 2002, and a further 87 were selected in 2006, but there are no details as to where they are to be located. The Primary Care Strategy promised €1 billion investment over 10 years. How much money has actually been spent on the Primary Care Strategy to date is not available. When asked, the HSE said €10 million was allocated in 2006 to enable the development of the 100 teams announced and a further €22 million in 2007. A total of €32 million is significantly short of the estimated €1 billion needed over 10 years.

Increased staffing A cap was put on health sector employment in 2002, ostensibly to contain spending and staffing. But as the introduction of the cap was based on inaccurate health spending figures, the cap achieved neither goal. Health sector employment has continued to grow in the private sector. During the lifetime of the previous government, the cap actually led to the closure of some wards and the crippling of some public services. While there has been some easing, it remains a constraint on service growth.

Care on the basis of need People who can afford private health care still access superior treatment faster in hospitals. If anything, this has worsened since 2002 and all the trends are in the wrong direction.

Reform & privatisation Congress believes reform is important and, in 2006 we proposed the establishment of a Health Forum, as the proper vehicle for this process, with all parties affected by the issue being party to devising the solution.

But to date, reform has focussed on two specific issues: the restructuring of the health services into the HSE and introducing greater levels of private provision, thereby weakening and undermining the public system.

We are entitled to ask, what has happened to the commitments outlined in the 2001 Health Strategy? What has happened to the commitment to provide care on the basis of need; to increasing the number of hospital beds, to increasing the number of consultants, doctors, physiotherapists, speech and language therapists, nurses and health care assistants; to creating a comprehensive and multi-disciplinary primary care system? All appear to have fallen by the wayside.

The establishment of the Health Service Executive (HSE) has taken the last remnant of democracy out of the health services – health boards no longer have local county/city council representatives on them. The vast majority of capital and current expenditure (95 percent) on health is now controlled by the HSE, yet it is unclear to whom the HSE is accountable.

Two thirds of parliamentary questions on health are referred from the Department of Health to the HSE, which does not answer 95 percent of the questions.

There is significant discontent among health service staff over the manner in which the HSE runs the service, with complaints of excessive bureaucracy and poor management.

Spending on health

Irish health care spending is inadequate, not excessive. On January 23, 2007, Mary Harney, then Minister for Health, stated: “Over recent years we have grown public investment in health at unprecedented rates. We have increased public health spending at one of the fastest rates among developing countries. Public health spending is now 78 percent of total health spending in the country – higher than the OECD average.”

This claim is misleading.

Figures for total health spending are unreliable. The inclusion in the health budget of money spent on social services - a feature unheard of in many other countries - artificially inflates the total.

While we trebled current spending between 1997 and 2004, this increase took place in the context of almost three decades of under spending and underinvestment.

Between 1970 and 1996, our average spend on capital investment was just 63 per cent of the EU average. In 1990, it fell as low as 38 percent.

Consequently, spending increases are still making up the shortfall resulting from almost 30 years of neglect.

Between 2005-2006, funding for hospitals was actually cut.

In addition, all spending increases must also be set in the context of inflation and increased costs, so a proportion of every increase is required simply to stand still.

The plain fact is that our day to day spend is well below the EU average. In 2004, the latest year for which valid international comparisons are available from the OECD, we spent 90 percent of the EU average. In fact, there is reason to suspect that it could be even lower.

The way in which money was allocated to the health service changed in 2005, with the establishment of the HSE making it more difficult to properly track.

One effective way is to examine money allocated in headline areas - hospitals being a good example. Money for hospitals is now allocated through the National Hospitals' Office (NHO).

In 2004, the NHO's allocated budget was just over €4 billion. In 2005, it jumped to just over €4.4 billion. In 2006 it rose slightly to €4.54 billion. With inflation running at approximately five per cent (according to the Central Statistics Office's proxy for public service inflation), that means the money allocated to run hospitals rose five per cent between 2004 and 2005.

But between 2005 and 2006, funding for our hospitals was actually cut, in real terms, by 1.81%. So much for the spending 'black hole'. In response to these figures the HSE said "the schedules to the vote for 2005 are not a reliable source as the vote was only introduced in 2005 and there was no experience of vote management."

Although the HSE now says Department of Finance publications cannot be trusted as a record of its spending on hospitals, they are the only published figures available. The Revised Estimates are published annually and presented to the Dáil in February after spending adjustments and announcements from the budget are incorporated. They are the official record of how public money is spent in the previous year and are presented to the Dáil for accountability.

The HSE said that final figures are available in the Annual Appropriations Accounts published by the Comptroller and Auditor General. However, these do not give details of the breakdown in spending.

The 2001 Health Strategy required substantial and sustained funding to repair the damage done by decades of neglect and to create the world class service to which we aspire.

Investment in social services is particularly important as current services do not meet the needs of older people and those with disabilities. Naturally, they then turn to the general health service to meet their needs.

Costing of the major Health Strategy targets for acute beds, long-stay beds and primary care centres suggests that a doubling of capital investment and an extra 10 percent of current spend every year, over a decade, would be enough to deliver on these promises. It is less than we currently spend on roads and transport.

Hospitals

While it is accepted that more hospital beds are required, there are other measures which can help address both the horrendous scenes in our A&E departments and the lengthy waiting lists for essential procedures.

Thus, a contributory cause of the ongoing A&E crisis is the lack of 'long-stay' beds, particularly for older people. When spending on hospitals was slashed in the 1980s and 1990s, social services also suffered. Consequently, our primary, community and continuing care systems remain underdeveloped.

But they are essential for a properly-functioning health service. Properly developed community-based preventative and continuing care services mean that less people will need to resort to hospitals for care.

The 2001 Health Strategy accepted the shortage of hospital beds and recommended 3,000 more public beds in acute hospitals over ten years (2,800 of those beds were to be inpatient). Had we started introducing the new beds then, we would now be more than halfway there.

Instead, we have fallen spectacularly short and by 2005, which are the most recent figures available, just 724 new beds out of a promised 3,000 had been delivered.

As current expenditure on hospital services has not increased significantly over the last two years, even falling in some cases, it is no wonder that hospitals are at bursting point, that essential surgery is cancelled and that queues on trolleys remain a feature of A&E departments across the country.

Medical Card Eligibility

Having a medical card entitles holders to 'free' essential health services including hospital care, GP visits, and most medicines. Access to medical cards is means-tested and applicants must show that they cannot afford to pay for medical care for themselves or their dependents, "without undue hardship." Some medical conditions also entitle people to a medical card. Having a medical card does not entitle the holder to 'free' services such as counselling and preventative services, eg cervical smears.

As of February this year, 29 percent of the population had medical cards. Nearly three percent of these were over 70-year-olds who did not have a medical card when they were 69 and qualified merely on the basis of age. That means that 26% of the population qualified for a medical card on the basis of income or medical need.

Twenty five years ago, in 1983, that figure was at 38 percent, falling in successive years to its current low level.

Despite increases in the eligibility threshold medical card guidelines have not been kept in line with rising incomes, resulting in many low income families failing to qualify.

In February 2007, some 55,578 people held 'GP visit cards' – entitling people to free GP visits, but not prescriptions. Yet, when the scheme was announced in 2004, the promise was that 200,000 cards would be issued. Because of the cards' limited nature, uptake has proven slow. Since July 2001, all over 70s have been entitled to medical cards.

The estimate of 2800 beds must be viewed as a minimum requirement

Inpatient beds in public hospitals

'Acute beds' are at the heart of the public healthcare system, as these are the beds designated for the diagnosis, treatment and care of seriously ill or injured people.

Thus, the number of acute beds in any system is crucial, as these beds are where the bulk of treatment takes place and on which there is the greatest demand.

In 1981, Ireland had 17,668 acute beds for a population of 3.4 million people - a ratio of 5.13 per 1,000.

The swingeing cutbacks of the 1980s and 1990s meant that by 2000 there were just 11,891 beds for a population of 3.8 million people – a ratio of 3.14 per 1,000, a very significant drop.

Investment since then has seen small increases in the number of inpatient beds, while the intervening years have also seen a major rise in 'day procedures', where no overnight bed is required.

So, by August 2005 there were 12,571 acute beds in the system, a small rise.

But population increases mean the crucial ratio has dropped further, to 3.04 per 1000.

The HSE carried out a bed count soon after their establishment, in August 2005. That count showed another fall, with acute bed numbers down to 12,211 and the all important ratio at an all-time low of 2.96 per 1,000.

The EU average is 4 per 1,000.

If the National Health Strategy had been acted upon promptly in 2001, we would have seen an additional 650 beds delivered by the end of 2002, representing "the largest ever concentrated expansion of acute hospital capacity in Ireland," as the Strategy itself described it. Instead, just 228 beds had materialised by the end of 2002, a shortfall of 372. Progress has slowed since then.

It is also important to realise that the Health Strategy and other studies which informed it, may have been based on inaccurate forecasts in relation to population increase. In 1990, the CSO forecast the 2006 population to be 4.05 million. In fact, as census findings reveal, our population has actually grown to 4.2 million.

Thus, it can credibly be argued that the Health Strategy estimate of 2,800 beds must be viewed as a minimum requirement.

A recent ESRI survey on hospital bed capacity found that an extra 2,277 beds are needed from 2007 to 2012 to meet the population needs: which would mean delivering an extra 380-400 beds per year, starting immediately.

The HSE is currently carrying out a major review of Acute Bed Capacity in Ireland. The review will examine the number and nature of hospital beds in the Irish health system and make an assessment of bed capacity requirements for the Irish population up to 2020.

Day beds

There has been an apparent increase in beds used to conduct day procedures, or 'day beds'. In 2001, there were 771 day beds available. In August 2005, official figures showed this had risen dramatically to 1,246 day beds.

However, this dramatic rise in numbers derives from a redefinition of what constitutes a day bed to include trolleys, recliners and couches....in short anything on which a patient can lie down, sit on, or recline, to receive medical treatment.

Equal Access

Hospital patients are either public or private. All residents of Ireland are eligible to be treated in the public system. People with medical cards (see panel on page 8) are entitled to hospital services free of charge. People without medical cards (over 70 percent of the population) pay a €60 per day rate for a maximum of ten days, if in hospital without a medical card or private insurance.

This entitles you to a bed in a public ward, appropriate hospital services and consultant-led treatment. But more often than not, public patients are treated by non-consultant hospital doctors (NCHDs), who are less experienced and generally overworked trainees.

Public patients wait longer than private patients. They wait longer to see a specialist and to receive appropriate treatment.

Private patients' hospital care differs from public patients in three main ways.

Firstly, they wait less to see specialists and receive treatment. Secondly, they always receive consultant-provided care and, thirdly, they may be placed in a private, or semi-private room.

This is the essential structure of our two-tier health system where care is provided on ability to pay rather than need.

This inequality is further reinforced by the fact that treatment for private patients is subsidised by the taxpayer. It is estimated that private patients – or their insurers – pay just 60 percent of the cost of their care. However, the figure could be as low as 40 percent of the cost of care, the figure cited by then Health Minister Mary Harney, in a March 19 interview.

Furthermore, the Brennan Commission recently revealed that private patients were often not charged for certain services provided in public hospitals, with public hospitals forgoing €1 million annually in fees.

This inequitable system is the reason that 52 percent of the population buys subsidised private health insurance. They do so to avoid the delayed treatment that public patients experience. There is also evidence to show that, increasingly, people who are not insured and who do not have medical cards are going into debt to pay for private care.

The A&E Crisis

The A&E department is the only sector of our health system that does not differentiate between patients on the basis of income. Everyone in need of urgent medical hospital care must enter through the A&E department.

In November 2004, Health Minister Mary Harney announced a 10 Point Plan to resolve the A&E crisis. In September 2005, Brendan Drumm, the then new chief executive of the HSE said it would take two years to solve the problem. In October 2005, the Irish Nurses Organisation (INO) started collecting and publishing daily tallies from A&E's across the country. Their 'trolleywatch' became a grim, daily reminder of the chaos in our health system.

11 days later the Minister declared the A&E crisis a 'national emergency'

In March 2006, actor Brendan Gleeson, articulated the rage and sense of helplessness felt by many with direct experience of the A&E nightmare, when appearing on the *Late Late Show*.

A Baboon Could Sort This Bloody Thing Out

“ My recent bugbear is the health system and I have become increasingly distraught at what's happening in the A&E situation. In the hospital where my own parents have gone in (to Beaumont Hospital) and my mother in law has been recently in.... the staff (there) are immense in the place, the people, the cleaners, the nurses, the doctors who are working in those places. But it's like a military field hospital. They're absolutely out on their feet. They are doing everything possible to alleviate the suffering and the pain that's there but systematically, bureaucratically, the place is a disgrace, I mean it's a war crime what's happening in there. Old people particularly are being left on trolleys ad nauseum until they, you know, some of whom have died... My dad was in there for I think about four or five days, a number of years ago. It was such a hideous experience (for him) that the last time, we nearly lost him because he was so reluctant to go through the A&E experience (again). He very nearly went, he was very close to dying because he could not face what was going on in there.

My mother was in there for three or four days and there was one toilet in the A&E in Beaumont Hospital. The indignity of it was unspeakable, but there were two other people there. The three of them got together and at one stage one of them had gone to the toilet, and a nurse came up and tried to sweep away the trolley that this

woman had been on for two days. My mum had to put down her hand and say, 'you're not taking that trolley because she's only gone into the toilet'. Now this is [a country] where we're making billions. This has been going on and on for years and years.

There are people here whose parents are going to die in disgusting circumstances. The staff are keeping the people as much as they can in some sort of human situation but this is absolutely disgusting. John O'Shea of Goal should come into Ireland and we'll give him some charity money and let him sort out what they are doing to our own people.

I want to ask here and now that anybody, if they don't sort this thing out in three to six months, anybody who votes for this crowd to get back in next time, might as well kill themselves. I'll be honest with you, I don't think much of the other crowd either.

It's disgusting that we are allowing people to die when we have billions, we have billions. A baboon could sort this bloody thing out.....”

Two days later, on March 19, the HSE announced the opening of admission lounges in A&E departments. Eleven days after Brendan Gleeson's now famous tirade, then Minister Harney declared the A&E crisis to be a 'national emergency' and set up a Task Force to find solutions.

The following month, the INO revealed that 495 people were on trolleys in A&E departments nationwide, the highest figure ever. Despite repeated official claims of progress, it is clear that problems persist, with Beaumont Hospital recording 52 people on trolleys, in February 2007, with a subsequent national count from the INO showing the figure remained well above 400.

The Task Force established to deal with the 'national emergency' has completed its work, but the report was not published until after the May 2007 election. It found a lack of beds in the system and hospitals running at full capacity.

Health service staffing

In 2005, there were 1,947 consultants working in public and voluntary hospitals. Of that number, 650 were entitled to work in private hospitals. Only an estimated 227 worked exclusively in private hospitals or clinics.

In addition, 4,170 trainee doctors (NCHDs) were employed in the public health system and a further 70 in the private sector.

This translates into 0.5 consultants (public and private) per 1,000 people. The EU average is 1.85 per 1,000 people (the Irish figure rises to 1.55 per 1000 when NCHDs are included).

The Hanly Report (2003) had already recommended a doubling of consultant numbers to 3,600, by 2013.

Any analysis of staffing in Irish hospitals has shown that there is a serious overdependence on NCHDs - junior trainee doctors.

Consultants' salaries range between €144,000 and €178,000, but this does not include their private fees. There is no accurate data kept on private fees, just as no records are kept on how their hours are spent, even if they are obliged to provide 33 hours to treat public patients. While the 2001 Health Strategy envisaged considerable increases in consultants, GPs, nurses, midwives, professional therapists, administrators and home helps, it did not detail specific numbers for most professions.

The cap on public sector employment introduced in December 2002 has had very negative impacts on the provision of public health and social services. Wards were closed, home helps cut and community care services suffered.

Despite the cap, expenditure increased in some areas due to a shift to private provision. So, while nursing numbers were curtailed there was increase in the use of agency nurses, which is more expensive.

Thus, we have the absurd scenario where an increased population creates increased demand for services and the health service, for political reasons, can only have recourse to the highest cost solution.

The National Treatment Purchase Fund

The National Treatment Purchase Fund (NTPF) was set up in 2002 to reduce waiting times for public patients for some medical treatments. The Health Strategy had stated that "by the end of 2004, no public patient will have to wait more than three months to commence treatment, following referral from an outpatients department."

While some progress has been made on waiting times, many public patients still face an overly long wait for treatment.

As of December 2006, there were 15,096 adults waiting for surgical procedures. Of these, 32 percent had been waiting over 12 months, 37 percent for 6-12 months, while 31 percent were waiting 3-6 months.

The National Treatment Purchase Fund buys private care for public patients. Much of this private care takes place in public hospitals and is subsidised by the taxpayer.

While the NTPF does reduce immediate pressures on the public system, it does not address the reasons which cause the delays in the first place - quite literally, it addresses symptoms rather than causes.

Consultants who don't get to treat a patient publicly due to long waiting lists, will instead get to treat the patient privately. This disincentivises consultants from eliminating public waiting lists.

A 2005 report by the Comptroller & Auditor General (C&AG) found that 36 percent of NTPF treatments occur in the same hospital where the patient was previously a public patient.

The report also found huge variations in rates paid for the same procedures by the NTPF, with the highest rates for some procedures sometimes 2-3 times higher than the lowest.

Public patients who undergo NTPF-funded procedures in private hospitals may be denied free follow-up care such as physiotherapy, which they would have got if treated in a public hospital.

The NTPF is not the best way to use public money to address long waiting lists. It may also result in poorer follow-up care for these patients who utilise it. If the money invested in the NTPF was invested directly in public hospitals, it would be possible to provide speedier consultant delivered care for all patients (not just private patients).

Private healthcare

Ireland has always had a unique and unequal mix of public and private healthcare. This arose due to the State's (alleged) historic inability to fund a national health service, along with ideological

opposition from the medical profession and Catholic Church alike. For public patients it can be a lottery of life and death, as they rarely if ever see their consultant and care is provided by less experienced junior hospital doctors.

I am going to die because of hospital waiting lists

A woman called 'Rosie' sent an email to the RTE Radio's Liveline, hosted by Joe Duffy. The email was entitled 'I am going to die because of hospital waiting lists'. Rosie spoke live on the show on January 9, 2006, detailing how she had waited seven months for a colonoscopy to diagnose her bowel cancer. The day before she wrote to Joe, she met another patient receiving chemotherapy for the same condition.

He was a private patient who had got a colonoscopy and was diagnosed within three days of seeing his GP. By the time Rosie was diagnosed seven months after attending her GP, it was too late. She was given three years to live.

Rosie is 40, and has two teenage children. She is currently undergoing chemotherapy to prolong her life. She was prompted to write the original email by a radio ad encouraging people to check for bowel cancer. Rosie's story crystallised the public-private divide in healthcare and created a huge public outcry the inherent inequality of the system. Dozens of people subsequently rang Liveline with similar experiences of differences in waiting times for diagnosis and treatment.

'Rosie' subsequently went public. Her name is Susie Long and she lives in Kilkenny with her family.

Public patients subsidise a better service for private patients

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Two-tier health system

Irish health policy actively supports the treatment of private patients in public hospitals. The state has allowed the development of two separate waiting lists, one for public patients and one for private. As private patients are seen to more quickly, this acts as an incentive – if not a compulsion – to buy private health insurance.

Latest figures show that 52 percent of the population have health insurance, an extraordinary phenomenon in a state where all qualify for public care.

The treatment of private patients in public hospitals happens for two reasons. Firstly, since 1991, all public hospitals must designate a proportion of their beds as private. Consultants are thereby facilitated to treat these private patients, while being paid a public salary for the treatment of public patients.

In 2002, 20 percent of beds in public hospitals were private, the recommended designation by the Department of Health. However as hospitals budgets have tightened, many now depend on income from private patients and insurance companies, meaning the percentage of private patients treated is higher than the percentage of privately designated beds.

At the end of 2006, the HSE warned Tallaght Hospital that the number of private patients they were treating was, at 40 percent, twice the norm.

Although more recent figures are not available for the sector as a whole, it is alarming that in 2004, in excess of 33 percent of all patients discharged after elective treatments were private.

Private patients do not pay the full cost of their care – many facilities are paid for by the public

system, such as operating theatres and nursing staff. In effect, public patients subsidise a better, faster care for their private counterparts.

Secondly, consultants in Ireland have contracts, which allow them to practice privately as well as publicly. Since 1997, the state has not offered ‘public-only’ contracts to consultants, thus incentivising consultants to practice private care.

The HSE is in the process of renegotiating consultants’ contracts.

Private Healthcare

Private healthcare focuses on younger, healthier patients who require less complex and more profitable treatments, a process known as ‘cherry-picking.’ Consequently, patients requiring longer-term, more complex and expensive care fall back on the public system.

In addition, in a system where private patients receive subsidised care in public hospitals, the more costly aspects of their treatment are invariably borne by the public system.

International research consistently shows that the cost of private for-profit care is significantly and systematically higher than not-for-profit care and that private care actually produces worse results.

Incentivising private care

Generous tax incentives to encourage the construction of private hospitals and nursing homes, were introduced in 2002. For every €100 million in hospital construction, the Exchequer gives €40 million in tax breaks to investors, who put up just €20 million of the cost. Hospital promoters usually would put up a further €20 million and the banks would lend

the remaining €60 million. Thus, the taxpayer effectively funds the equivalent of all the risk.

And for that €40 million subsidy, the taxpayer gets absolutely nothing in return: no extra beds are added to the public health service; the taxpayer has no control over, or interest in the new facility. And should the owners decide, in perhaps 15 years time, that there is more profit to be had from a supermarket or high-end apartments, the hospital can be sold off and the €40 million subsidy will not be returned.

Three years after the introduction of these subsidies, then Health Minister Mary Harney launched the 'co-location initiative', which would see up to 10 private hospitals built on the lands of existing public hospitals.

Her stated aim was to free up 1,000 private beds in the public system by effectively relocating them to the new (subsidised) facilities. The plan was announced as being 'cost-free' to the exchequer, until it was pointed out that the tax breaks could result in a bill of over €400 million. And to this sum should be added the cost of the public land on which the new facilities will be constructed.

The 'co-location' plan is simplistic in the extreme. It will not result in the freeing up of 1000 beds in the public system.

Private hospitals cannot and do not provide the same level of care as in the public system. For example, private hospitals will not provide 24 hour A&E departments as they would find the costs prohibitive, when set against likely income.

Approximately 68 percent of all admissions to our hospitals are made through A&E, many of them older people not requiring surgery. Private hospitals focus on planned surgery rather than emergency or essential care and they avoid other expensive treatment, such as care in stroke units. So they select relatively quick and straightforward procedures that require little follow-up care. Indeed, if follow-up care is needed, the patient will fall back on the public service.

Private hospitals will continue to 'cherrypick', while public hospitals will continue to provide more complex and costly services, including complicated surgical procedures and expensive but lifesaving rehabilitation treatment.

As you are not comparing like with like, you cannot possibly expect that 1000 extra private beds - in co-located private hospitals will automatically free up 1000 public beds. What you can expect is that the inequality in the health system will be further entrenched, with private care privileged over the public system.

Negotiations between private hospital developers and the HSE are ongoing and are being conducted in secret.

Some HSE statements suggest that private hospitals will not be allowed to 'cherrypick' and will be obliged to take long-stay medical patients and A&E cases. It seems highly unlikely that private developers would agree to such a model, as it is unlikely to generate sufficient profit.

The taxpayer gets nothing in return

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Indeed if developers were to agree to operate such hospitals, we would see a quite irrational duplication of facilities, in close proximity, with two separate managements drawing on the same consultant workforce.

This latest scenario appears to envisage a public health service in which ambulances would choose their destination based on the insurance status of their patients and in which the state would effectively fund two A&E departments – one public and one private – on multiple sites all over the country. The more we learn about the plan the less sense it makes. Equally, it runs counter to stated commitments (as in the Hanly Report) to developing centres of excellence in emergency hospital medicine.

It is far more probable that private hospitals on the grounds of public hospitals will be typical private facilities, which will further institutionalise the unfair and unnecessary two-tier health system.

This strategy will result in an increase in private beds, partially paid for by public money. As consultants are paid a fee for each private patient, while they are paid a salary for all public patients, the incentive to treat private patients across the hospital grounds continues. Also if consultants are shareholders in the private hospital (and many who work in private hospitals are), there is a further incentive to prioritise the treatment of patients in the private hospital, over the care of public patients in the public hospital.

Perverse financial incentives

General practitioners (GPs), consultants and hospitals are all paid differently for the treatment of public and private patients. This creates perverse incentives and favours the treatment of private patients.

GPs are paid a set rate for every patient with a medical card (the rate is determined by the patient's age and distance from the GP surgery).

All other GP patients (over 70 percent of the population) pay a fee each time they visit the GP, usually around €50. This incentivises GPs to see patients who pay per visit more often than those for whom they are paid a flat rate. But people who qualify for medical cards are by their nature older and less well-off, thereby requiring more GP care.

The exception to this is all over 70-year-olds who, since 2001, are entitled to a medical card. However, once again there is an incentive to provide care for over 70s who previously did not have a medical card.

When the new over 70s card was introduced, it was agreed to pay GPs between 2.6 and 4.6 times the existing medical card rate. Thus, GPs are again incentivised to see those over 70s in possession of the new over 70s cards, the majority of whom would be both wealthier and healthier than those who had qualified for medical cards on the basis of need.

Consultants are paid by salary for their public patients, while private patients pay for each visit and procedure, usually through their insurance company. Consultants are required to spend 33 hours per week with their public patients. Often consultants have private and public patients in the same hospital. As patients can get a quicker service through private care, and consultants get a fee each time they see a private patient, both parties are incentivised to utilise medical care.

Consultants should be paid for all patients in the same way, a combination of salary and fee

for service would eliminate current perverse incentives and the unfair two-tier health system. Hospitals are also paid differently for public and private patients.

It is imperative a common waiting list is adopted across our health service, with no differentiation between public and private. This would help end the spectre of two-tier care, with treatment delivered on the basis of need, not income. Equally, public money must not be used to support or develop private health care. The 'co-location' plan will cost taxpayers hundreds of millions and deliver few benefits. Left unchallenged, it has the capacity to do irreparable damage to the public health system.

Primary Care, Community & Continuing Care

Primary Care

Primary care in Ireland is centred on GPs, who act as a gateway to specialist and other services. It is usually the first point of contact with the health service for most people and it can be the service that meets 90-95 percent of all health and social care needs.

But primary care remains underdeveloped in Ireland. Associated services like physiotherapy, speech and language therapy, often don't exist or are plagued by waiting lists. Community and continuing care services (mental health services, for example) are also underdeveloped. In most other European countries, people have access to GPs, community health and continuing care services for free or at a very low cost. In Ireland, 70 percent of the population pay a fee each time they attend the GP. In addition they pay for drugs prescribed at the GP, up to a cost of €85 per month.

GPs in Ireland are private self-employed operators whose services are contracted by the HSE. Most provide services for both private and medical card patients.

Improving access to primary care services is central to a more effective health service. Much of the demand on hospital services – such as A&E – would be significantly reduced if there were adequately resourced primary, community and continuing care services.

That was the goal of the Primary Care Strategy – *Primary Care: A New Direction* – which was published in 2001. This set out a clear plan for primary care as the central focus for the delivery of health and personal social services. Six years on, it has still not been implemented.

At its heart was the development of a national network of multi-disciplinary Primary Care Teams, each serving a catchment area of approximately 3,000 people. In 2002, ten pilot teams were established. In 2006, 87 teams were 'selected' but they are not yet actually up and running.

Funding for another 100 teams was announced in December 2006, with the teams to be selected this year.

Towards 2016 commits to "a target of 300 primary care teams by 2008, 400 by 2009 and 500 by 2011."

However, uncertainty remains as to the available funding and, thus, the entire strategy remains in some doubt.

The goal must be free GP care for all

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Poorer areas have fewer GPs, but a higher demand for their services and a higher usage of A&E. GPs providing services in areas of deprivation believe long waiting times for community services and to access hospital services, puts increased pressure on already poor primary care services.

Comparative North-South research shows that people in Northern Ireland visit their GPs more often than people in the South. In Northern Ireland, where everyone has equal access to a GP at no cost, there are 3.8 GP visits per person per annum. South of the border, there are 3.3 visits per person per annum.

Medical cardholders in Ireland average 5.8 visits per annum whereas non-medical cardholders visit 2.2 times per annum. This seems to clearly indicate that the existence of a fee acts as a deterrent to accessing the GP service, thus increasing pressure on hospital services and A&E departments.

To address the problem, medical card eligibility must be restored to 35-38 percent of the population. Those with GP visit cards should receive full cards. Ultimately, the goal must be to provide free GP care for all.

Long term care for older people

Ireland has a younger population than our EU counterparts, which gives us time to plan and invest in good quality services for older people. In April 2006, there were 471,000 people aged 65 and over (11.1 percent of the population). Across the rest of Europe that figure rises to 17 percent.

The Leas Cross Scandal put the care of older people firmly on the political agenda. As far

back as 2001, the Health Strategy identified inadequacies in existing services for older people.

The Strategy promised 5,600 extended care/ community nursing places over seven years, 600 additional hospital bed places, 1,370 additional rehabilitation and assessment beds, 7,000 day centre places, and improved staffing for day and residential units.

While there has been significant investment in care for older people since 2001, the cap on public sector employment has hampered the proper development of services.

In 2006, for example, 1,050 beds were contracted from the private nursing home sector but no new public beds came on stream. Equally, in the same year we saw an extra 2,000 home care packages – all contracted from the private sector, while the number of home helps in the public sector actually declined!

This is not a sustainable approach – unless the ultimate intent is to privatise the service.

In terms of residential care for older people, it is well known that private care cannot meet the needs of high dependency residents. The increased dependency on the for-profit private sector is problematic as it does not offer the same range of support for patients with high levels of care and medical needs.

Also, as the location of private homes is unplanned, they may not be matched to needs of patients. Plans are now in place for additional community nursing units, which is a welcome development.

Tax breaks for building private sector nursing homes and the public sector cap on health service have meant that the strategy and promises outlined in 2001 have not been realised.

Older people are no longer entitled to free long-term care because of legislation passed in 2005 following a Supreme Court ruling that it was illegal to charge them for their care.

Previously, older people had been entitled (under the 1970 Health Act) to free in-patient care, including long-term residential care. The nursing homes scandal revealed the state to be illegally charging people for that care.

Since July 2005, people pay 80 percent of their pension towards their care. Those in private care pay most or all of the cost, depending on the level of state subvention.

As of January 2008, any older person assessed as needing long-term care will be required to pay 80 percent of their disposable income towards the cost of care. If a person's disposable income is less than the cost of care, under the Fair Deal scheme announced in December 2006, five percent of the market value of their house will be sought for a maximum of three years. The average income of over 65s is €235 a week. Nursing home care can cost up to €1,000 a week.

Up to 15 percent of the value of their home will be payable after death by residents of both private and public nursing homes.

While older people live longer, they also live healthier and fitter lives. Fewer older people are in need of long-term residential care than before. Less than five percent of those over 65 are in residential long-term care at any one time. Yet, there are still insufficient numbers of carers and home helps and there are still no dedicated nursing home inspection teams in place across the country.

International research has found that the costs of publicly providing for nursing home care for an older and healthier population can be met within the parameters of all reasonable forecasts of economic growth.

Community & Continuing Care

Community and continuing care services include public health nursing, home help, physiotherapy, speech and language therapy, social workers and a wide range of other services including community mental health services. They too suffered cutbacks in the 1980s and remain underdeveloped. The planning, funding and provision of community and continuing care should be based on a proper needs assessment, as opposed to the ad hoc approach that dominates now.

Mental health services

Spending on mental health declined from 10.7 percent of the overall health budget, in 1990, to 6.6 percent in 2005. Spending on mental health services in Northern Ireland is 9.2 percent of overall budget, and 11.6 percent in England and Wales.

Annual reports from the Inspector of Mental Health Services and the Mental Health Commission have repeatedly detailed serious deficiencies in acute mental health provision, the virtual absence of inpatient beds for

adolescents, deficiencies in community care services for people with mental health difficulties and illnesses - in particular for those who have been moved from institutions to the community without adequate supports. The absence of preventative mental health services is also a serious problem.

While a new policy on mental health - *Vision for Change* – has been published, it will have little impact until funding deficits are addressed and restored to 1990 levels.

Glossary

Acute hospitals are hospitals which diagnose, treat and care for seriously ill or injured patients by providing medical and surgical treatment for a relatively short period of time.

Capital funding is money allocated to be spent on health service assets such as building and equipment which will be used for longer than one year.

Current funding is money allocated to be spent on the day-to-day running of the health services.

An elective procedure is one that is chosen (elected) by the patient or physician that is advantageous to the patient but is not urgent, Primary care is care that includes a range of services which are designed to keep people well, such as health promotion, screening for diseases, assessment, diagnosis, treatment and rehabilitation as well as personal social services.

Primary care is often the first point of contact with the health services.

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