



Equity of Access to Hospital Care

Forum Report No. 25

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Foreword

This is the first time the Forum has undertaken some work in the health area. The Forum's mandate, as given to it by the Government, relates to the preparation of policy advice on social inclusion and equality issues. Given the widespread concerns on what has been called a 'two-tier health system', it is not surprising, therefore, that the present Report focuses on the promotion of equity in access to hospital care, with particular reference to reducing waiting lists and waiting times for public patients.

The Report is intended to contribute to the on-going and wider public debate on improvements to our healthcare system and the particular need to give greater priority attention to addressing the inequalities in health status between different groups in our society.

After a good deal of deliberation, including an examination of debates and practices elsewhere, the Report comes down to a very clear understanding that equity in access to healthcare should mean access on the basis of medical need or capacity to benefit from care, and should not be affected by other factors such as ability to pay or where one lives.

With its central concern about access to acute hospital care, the Report emphasises strongly the need to shift to trying to capture waiting time, rather than solely that of the numbers appearing on waiting lists, and also to capture within that, not just the time spent waiting before one sees a consultant, but also to the time it takes to receive in-patient treatment.

The Report welcomes and believes that the Government's recent Health Strategy, together with its parallel document on Primary Care, can achieve greater equity in access to healthcare for the most vulnerable groups in our society. However, it records a number of concerns such as inequities in time spent waiting for the first consultant appointment, clarifying and codifying rights and entitlements for those with and without medical cards, prioritising all admissions to public hospitals by reference to medical need, and quality standards for delivery in both public and private hospitals. These need to be taken into account in the implementation of the Strategy and this should be undertaken on a social partnership basis, with the involvement of the Social Partners.

The Forum considers that structural change may be necessary to the current public-private mix in our system of hospital care to ensure that patients are dealt with on an equitable footing. To this end, it recommends that an independent study be undertaken of alternative models and structures in other countries and that this should be given priority.

Finally, the Report was prepared by a Forum Project Team and takes into account consultations with a range of medical experts and interest groups, including two Plenary Sessions that included the wider Forum membership, as well as invited guests who had wide knowledge and experience of health policy issues.

Section I

Introduction
and Overview

Section I

Introduction and Overview

Focus and Objective of the Report

1.1 When asked about the main determinants of their quality of life, most people in Ireland – and indeed in our European Union partners – put health right at the top of the list. Health and healthcare have come to the forefront in recent years both in terms of public concern and policy focus. The Forum has wished for some time to contribute to this debate, from its own particular perspective of promoting equality and social inclusion. The preparation and publication of the Government’s new National Health Strategy, *Quality and Fairness: a Health System for You*, which identifies overarching goals to guide planning and activity in the health system over the next 7-10 years, provides an appropriate opportunity to make such a contribution.

1.2 This Report sets out the findings of the Project Team set up to carry forward the Forum’s work in this area. The terms-of-reference for this Project Team were as follows:

“Having regard to widespread concerns about the emergence of a ‘two-tier health system’ where public patients face long waiting lists for a range of treatments while those with private health insurance can avoid waiting lists and may benefit from higher quality healthcare within the public hospital system, and also having regard to the Forum’s mandate regarding social exclusion and equality, the Project Team on Health Policy will examine advantages and disadvantages of the mixed model of care delivery and advise on the development of policy in this area to promote equity in access to healthcare and to reduce waiting lists/waiting times for public patients”.

1.3 These terms-of-reference were framed in the light of the need to focus on priorities and delimit the scope of the project, rather than seek to cover the entire spectrum of issues in a very complex area. The issue of access to public hospitals is an area of particularly widespread concern, and the focus on the divergence between public and private patients reflects the emphasis in the Forum’s mandate on issues relating to inequality and its links to poverty and ill-health.

1.4 There are wide inequalities in health status between different groups in our society. This reflects a wide range of influences, including significant income inequalities. These inequalities in health are evidenced in indicators such as

those of life expectancy, mortality and sickness. Another factor is geographical remoteness in access to health services.

- 1.5 While critically important, the issue of access has of course to be seen in its wider context. Even if one were only concerned with access to hospital care, what goes on outside the hospital sector will have an enormous influence on the demand for hospital care and the way that manifests itself. The determinants of health, and the factors producing marked inequalities in health status across socio-economic groups, are many. Health services outside the acute hospital sector have a key role to play, and better delivery of healthcare – in and outside hospitals – has increasingly come to be recognised as only part of the broad-ranging strategy required to improve population health and reduce health inequalities.
- 1.6 This is reflected in the emphasis given in the Government’s new Health Strategy on a major development of primary care services and on the need for a “*whole-system approach*” to tackling health in this country going beyond the health services. However, the Strategy also emphasises the importance of developing and reforming acute hospital care, and – as detailed later on in this Report – recognises the depth of concern about access to public hospitals. By focusing here on this specific (and still extremely complex) area, this Report is intended to allow the Forum to make a contribution to on-going debate about how best to improve access to health and healthcare and reduce health disparities and inequalities.
- 1.7 Equity or fairness is widely regarded as a basic principle of health policy, and given its mandate, the Forum seeks to highlight issues relating to equity and ways of developing and reorienting the health services that improve both efficiency and equity. But how should equity be defined and assessed in this context? This is a key question, and has to be addressed at the outset.

What is Equity in Healthcare?

- 1.8 Taken broadly, equity in healthcare relates both to the way health services are financed and to the way they are delivered and accessed. Here, reflecting the terms-of-reference for the project, the concern is with access. What represents equitable access? A common formulation, and one that is fully supported by the Forum, is that access to care should be on the basis of medical need or capacity to benefit from care, and should not be affected by other factors such as ability to pay or geographic location. This is the way equity of access was defined in the Government’s official Health Strategy for the 1994-2000 period, *Shaping a Healthier Future*, for example, and is widely employed internationally.

- 1.9 Access to healthcare does not depend simply on what one is entitled to, since a formal entitlement provides little benefit if the services in question are simply not available or are not provided to an adequate level, or within a reasonable period of time. It may also not be obvious whether access is indeed equitable, since even if it were one would expect people with different needs to use services to a different extent. This means that equity in access across different geographical areas has been a preoccupation in some countries and health systems. In the Irish case, however, the over-riding concern and the focus of the present Report relates to differences in access between public and private patients. This represents an equity issue because, of course, public patients are generally less well-off financially than private patients. The fact that at present the better-off have speedier access to care in public hospitals violates the principle that medical need should be the determinant irrespective of ability to pay, and the extent of the perceived divergence appears to be widely regarded as inequitable.
- 1.10 Such a divergence can of course only arise within a public hospital system in the situation where private patients are often treated in public rather than private hospitals, as they are in Ireland. This reflects particular features of the way the our healthcare system has evolved, and the unusually close and complex interplay between public and private care. Moreover, some people's attitudes may well be different where private patients receive care in private hospitals, and their views about equity may then be influenced by whether such patients are seen as paying their own way. What is clear, however, is that equity in access to public hospitals, the perception that public patients may face long waiting times for certain types of care in those hospitals, which the better-off can avoid, has come to the forefront as an area of public concern and debate. It is on this, often referred to as the 'two-tier' system, that this Report primarily concentrates.
- 1.11 Having outlined the focus and objective of the present Report and opened up the discussion on the central issue of how equity is to be understood, the remainder of this Section presents an overview of the Report's structure and content and its key conclusions and recommendations.

Overview of the Report

Section II: Public and Private Health Services

- 1.12 Because the interaction between public and private is so central in the Irish case, the Report begins by describing the public-private mix in the financing and delivery of health services in this country. As our healthcare system has evolved over a long period, public provision developed incrementally as different services were made available selectively over time to those who could not afford them.

1.13 Currently, about 30 per cent of the population are eligible for free health services across the board, including in acute public hospitals, on the basis of income – that is, they are covered by a ‘*medical card*’. The rest of the population are now also entitled to care in public beds in public hospitals, subject to some statutory charges. Those who are in a position to pay – generally covered by health insurance – can however avail of private care. Reflecting the way the public-private mix evolved, a large part of privately-financed specialist care is supplied by consultants who also hold public hospital salaried contracts, and in many cases is supplied in public hospitals. About half of all private beds are in public hospitals, and these comprise about one in five of all beds in acute public hospitals.

Section III: International Perspective

1.14 This public-private mix is quite unusual compared with other countries, and this is brought out in the next Section of the Report. Firstly, in other countries with a universal publicly financed system, parallel private financing through private health insurance generally plays a much smaller role than it now does in Ireland. Secondly, the extent to which delivery of public and privately-financed care are interconnected rather than separated is considerably greater here than in other such healthcare systems. This means that the scope for ‘two tiers’ in terms of access to public hospitals is much greater in this country than in, for example, our European Union partners.

Section IV: Public-Private Mix and Equity of Access

1.15 The Report then outlines the way the public-private mix in Irish hospital care, and views about what is equitable in this context, have evolved. There has been a long-standing commitment in public policy to maintaining private practice both within and outside the public hospital system, and this has been reflected in the contracts agreed with medical consultants. The equity aspects of the public-private mix came to the fore in the 1980s, and were addressed by the Commission on Health Funding in particular. That Commission set out its understanding of equity, namely that access of patients to necessary healthcare should be determined on the basis of their individual need for the service rather than, for example, geographical location or ability to pay. This requires that these necessary services are available to a high quality and within a reasonable period to everyone. While those in a financial position to obtain medical treatment which is generally unavailable should be able to do so, the Commission believed that this should not be subsidised at public expense and should not act to the disadvantage of those of lesser means.

1.16 As far as private care in public hospitals is concerned, however, the Commission regarded it as inequitable that patients in medically similar circumstances do not have equal access and recommended that a common waiting list for all patients

be established. This was not adopted, although essentially the same definition of equity was spelt out in *Shaping a Healthier Future* in 1994. Instead, from the early 1990s the focus of policy has been on clarifying the boundary between public and private care in public hospitals – notably by designating the number of private beds in each public hospital and seeking to ensure that private care is as far as possible delivered only in those beds – and on increasing the charges levied for occupying private beds.

Section V: Waiting for Public Care

1.17 Much of the concern being expressed about the public healthcare system in Ireland focuses on access to hospital, and on the length of time people have to wait before they receive certain types of care. This is reflected – *albeit* inadequately – in data on the numbers on waiting lists for treatment in public hospitals. The Report explores the nature of the data available and its limitations, and examines key trends over time. This brings out, *inter alia*, the concentration of waiting – insofar as it is reflected in official data – in certain specialties, and the need for improved recording. This needs to focus on “*waiting times*” rather than the stock of persons waiting, and should incorporate “*time spent waiting*” to see a specialist as well as time spent from referral by a specialist to then receiving hospital care. The Report also points to the fact that, while some other countries do indeed have similar waiting lists, examples can be found of substantial reductions achieved in these waiting lists over a relatively short period.

Section VI: Policy on Waiting for Hospital Care

1.18 Looking in detail at policy in regard to waiting lists, the Report discusses the variety of Waiting List Initiatives which have been implemented here in recent years. It brings out first that the incentives implicit in such Initiatives may have perverse features. It also concludes that evidence from both Ireland and elsewhere on the long-term success of such measures is mixed. It also brings out that policies directed at reducing waiting times raise particular issues for equity in access across those waiting, since they are directly concerned with the criteria for prioritising patient access.

Section VII: Equity of Access in the New Health Strategy

Health Strategy's Provisions on Equity of Access

1.19 The Government adopted a new medium-term Health Strategy, entitled *Quality and Fairness: A Health System for You*, in December last. In reacting to this wide-ranging Strategy, the Report continues to focus on the specific issue of the public-private mix from an equity perspective: while this is a key concern, in doing so the Forum would not, of course, wish this to be seen as a

comprehensive response to the Strategy as a whole. The Report discusses first the way the Strategy thinks about equity of access, and then looks at how it intends to promote equity of access.

- 1.20 The new Strategy is explicit in setting out equity and fairness as among the key principles on which the health system must be based (along with a people-centred service, quality of care and clear accountability). It states that:

“Equity will be central to developing policies (i) to reduce the difference in health status currently running across the social spectrum in Ireland, and (ii) to ensure equitable access to services based on need” (p. 18).

- 1.21 In examining the problems in the current system, the problem of equity of access is specifically framed in terms of the contrast between public and private patients.

“One of the key concerns of the Health Strategy is to promote fair access to services, based on objectively assessed need, rather than on any other factor such as whether the patient is attending on a public or private basis. This is of particular concern in the area of acute hospital services. The current mix of public and private beds in the public hospital system is intended to ensure that the public and private sectors can share resources, clinical knowledge, skills and technology. This mix raises serious challenges, which must be addressed in the context of equity of access for public patients” (p.43).

- 1.22 The Strategy’s discussion on this issue is summarised in the following ‘key message’:

“Access to services to be more equitable – the perceived two tier aspect of healthcare to be eliminated” (p.57).

- 1.23 In its forthright recognition of this equity problem, and in its clear commitment to tackling the problem, the Report concludes that the Strategy represents an important advance that is very much to be welcomed.

- 1.24 Consistent with this emphasis, fair access is set out as one of the Strategy’s four overarching national goals – together with better health for everyone, responsive and appropriate care delivery, and high performance. Public entitlements for those with and without medical cards are to be clarified and codified in legislation in terms of entitlement rather than eligibility, the income limits for medical cards are to be widened, and “*equitable access for all categories of patient in the health systems will be assured*”. The Report once again welcomes these initiatives and commitments, seeing for example the focus on entitlement rather than eligibility as a step forward.

- 1.25 To achieve the objective of equitable access, action is to be taken on availability of information, the physical accessibility of health facilities, appointment planning and upgrading waiting areas, and improving access to hospital services for public patients through a series of integrated measures designed to reduce substantially the waiting times for public patients for elective treatments. Specific targets are set so that by the end of 2004, no public patient will have to wait for more than three months to commence treatment, following referral from an out-patient department.
- 1.26 As current national waiting lists only include those who have been waiting for three months, this target implies the elimination of waiting lists, as we have known them, by that date. The Forum has always supported the adoption of ambitious and challenging targets in addressing significant policy problems, and strongly supports the adoption of these bold targets in the Strategy.
- 1.27 A variety of measures are intended to achieve that outcome:
- acute hospital capacity will be increased and targeted more firmly towards acute public patients;
 - 3,000 new acute beds will be added to the health system over the next ten years, and since the priority is to increase access for public patients, all additional beds will be designated solely for public patients;
 - much more active waiting lists/time management will be promoted, with the new National Hospitals Agency managing a new national waiting times database, which together with new national guidelines will be used to inform referrals by GPs;
 - a Treatment Purchase Fund is being set up to purchase treatment from private hospitals in Ireland; for public patients who have been waiting over three months, and from providers in other countries, where necessary;
 - the balance between public and private practice in public hospitals will be managed to support timely access for public patients; and
 - action may be taken to suspend admission of private patients to a public hospital for elective treatment in a specialty until the target waiting time is restored.

Forum's Comments

- 1.28 In practical terms, then, the Strategy defines the problem to be addressed in terms of equity of access as reducing waiting times faced by public patients. The equation of equity of access with shorter public waiting times has characterised public policy debate at least since the Commission on Health Funding. What is new in this Strategy is the development of this approach, moving well beyond the

position taken in Government policy to date. The recognition in the Strategy that the public-private mix in the public system is part of the problem – with regard to both the physical capacity of the hospital and the allocation of consultant time marks an important policy change for the better. The Forum particularly welcomes the following:

- additional bed capacity provided from the public purse is to be designated exclusively for public patients;
- the capacity available to public patients is to be maximised by firm implementation of the designated bed allocations;
- the rules governing individual consultant’s allocation of their time between public and private patients are to be clarified and more clearly implemented;
- changes are proposed in the Consultant Contract under which new consultants would not engage in private practice for a number of years; and
- public hospitals must give greater priority to timely access for public patients, and achievement of this priority may sometimes require limits on private admissions to public hospitals.

1.29 Overall, then, the Forum believes that the approach set out in the Health Strategy (allied to the provisions in the Government’s parallel document *Primary Care – A New Direction*) can bring about a real improvement in the position of public patients as well as greater equity in primary care support for the most vulnerable groups in our society. Nevertheless, a number of concerns are registered.

Firstly, the Strategy makes no reference to time spent waiting for first consultant appointment after referral by a GP; the inequity between public and private patients in the waiting times for initial specialist appointments must also be addressed.

Secondly, public entitlements for those with and without medical cards are to be clarified and codified in legislation in terms of entitlement rather than eligibility. It is essential that this legislation should guarantee rights to treatment within a reasonable period, taking into consideration the limits of public resources, for instance. Everyone should have the opportunity for maximum health gain.

Thirdly, the Forum would wish to see a specific commitment to ensuring that all admissions to public hospitals – whether public or private – are prioritised in accordance with medical need.

Fourthly, the Forum regards it as critically important that any greater reliance on the private sector to provide for the needs of public patients should not undermine public provision. Common quality standards should be established and regulated, in both the public and the private sectors.

Fifthly, the Forum would emphasize the importance of adopting a fully-fledged partnership approach in the implementation of the Strategy.

- 1.30 Success in terms of the Strategy's targets would entail shorter waiting times for public patients – sometimes very much shorter – than at present, but public patients might still have to wait longer for essential treatment than private patients and not necessarily be treated in the same way when in hospital. This is seen by many as a result of the unusual inter-mingling of public and private, which the Strategy essentially leaves unchanged.
- 1.31 Finally, additional resources must be complemented through decisive action on the management weaknesses in the system that were pinpointed in the recent Deloitte and Touché *Value for Money Audit of the Irish Health System* report. Otherwise, achievement of the Strategy's goals and objectives will be seriously undermined.

Section VIII: Achieving Equity of Access to Hospital Care

- 1.32 The Government's new Strategy can achieve real improvements in the position of public hospital patients and contribute to reduced waiting times. However, the Forum considers that the public-private mix is a significant issue in relation to equity of access to hospital care.
- 1.33 In this regard, the Forum recommends that alternative models in other countries that do not have the same equity problems as we do should be independently investigated. This should be given the highest priority and followed-up at senior level. Any resulting reform, to be successful, must take as its starting-point the way our current system has evolved. Finally, the Forum concludes that the State must guarantee and ensure the availability of adequate healthcare to all, regardless of means. This is the only way that equity of access to hospital care can be achieved.

Project Team Membership

1.34 The members of the Project Team were as follows:

Sheila Cronin	Conference of Religious of Ireland
Councillor Tadhg Curtis	Association of Municipal Authorities of Ireland
John Dolan	Disability Federation of Ireland
Frank Flannery	Chambers of Commerce Ireland
Charlie Hardy	Department of Health and Children
Senator Mary Jackman	Fine Gael
Noreen Kearney	Independent
Deputy Liz McManus T.D.	Labour Party
Senator Paschal Mooney	Fianna Fáil
Betty Murphy	Irish Farmers Association
Tess Murphy	National Women’s Council of Ireland
Brigid Quirke	Community Workers Co-op
Breda Raggett	Irish Countrywomen’s Association
Eoin Ronayne	Irish Congress of Trade Unions
Dr. Joe Stynes	Senior Citizens Parliament
Professor Brian Nolan	Economic and Social Research Institute (Project Leader)
Laurence Bond	Forum Secretariat

Consultation Process

1.35 During the course of its work, the Project Team consulted with a range of experts and interest groups in the health sector. These included the following:

Dr. Michael Boland, Irish College of General Practitioners;
Mr. Bob Carroll, Director, National Council on Ageing and Older People;
Mr. Eugene Donoghue, CEO, An Bord Altranais;
Professor Muiris Fitzgerald, Professor of Medicine, UCD;
Mr. Finbarr Fitzpatrick, Secretary General, Irish Hospital Consultants Association;
Ms. Eithne Frost, Secretary, Neurological Alliance;
Dr. Kate Ganter, Consultant Child and Adolescent Psychiatrist;
Ms. Angela Kerins, Chairperson, National Disability Authority;
Mr. John Looney, Secretary/Director Finance, VHI Healthcare; and
Mr. Donal O’Shea, CEO, Eastern Regional Health Authority.

1.36 In addition, a written submission was received by the Team from the Women’s Health Council.

Section II

Public and Private Health Services

Section II: Public and Private Health Services

Introduction

2.1 Because the interaction between public and private healthcare is so central to the Irish system and to concerns about its ‘two-tier’ nature, it is necessary at the outset to identify the elements of that complex interaction. This Section, therefore, outlines in some detail the public-private mix in the financing and delivery of our health services and the way it has evolved. This is set out under the following headings and provides the background against which the Report then proceeds in its focus on equity of access:

- **Health Services Financing**

- *Public and Private Finance; and*
- *Private Health Insurance.*

- **Health Services Delivery**

- *Public Provision of Health Services;*
- *Delivery of General Medical Services; and*
- *Delivery of Hospital and Specialist Medical Services.*

2.2 The boundary between public and private health services may be defined in different ways.¹ We treat as public provision those services that the public authorities are legally mandated to provide. Such services are predominantly publicly-funded, but are supplemented in some instances by private financial contributions. Publicly-provided health services, understood in this way, are delivered by a mix of public and private sector agencies and professionals. While these are sometimes also referred to as providers, to avoid confusion we will generally refer to the deliverers of services as (public or private) suppliers.

2.3 Private health services are all other services, in effect those that are privately funded, whether out-of-pocket payments or through private health insurance. While privately provided in this sense, these services are delivered by both public and private suppliers and also attract public subsidies in certain instances.

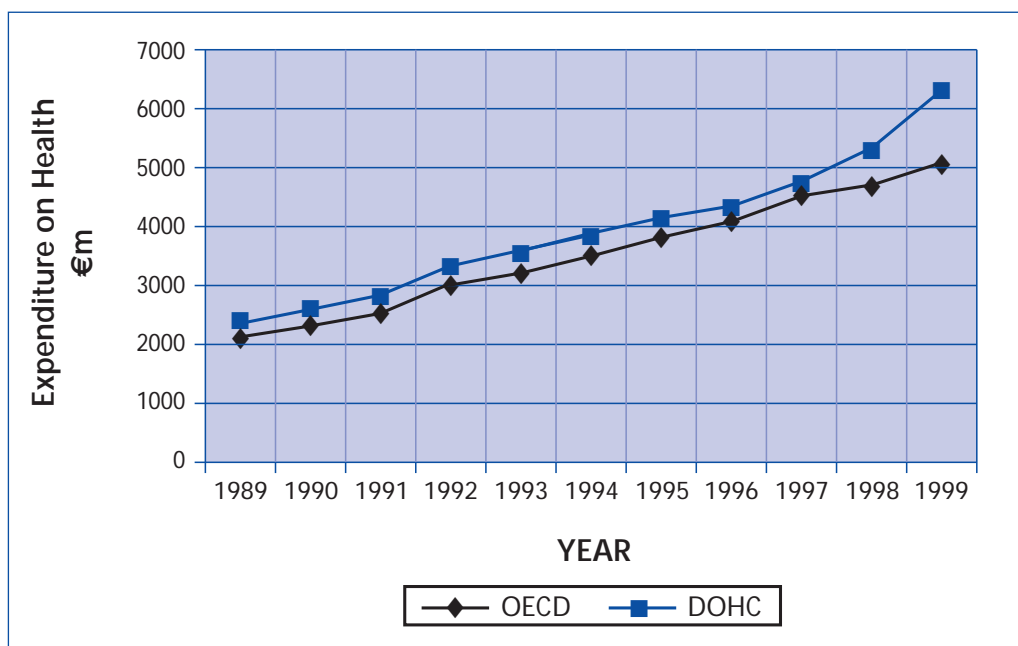
1. A public/private distinction in healthcare provision may be applied on the basis of a number of criteria such as financing, delivery and decision-making and these can be combined to construct more or less complex typologies. (Nolan 1991; Burchardt 1997).

Health Services Financing

Public and Private Finance

- 2.4 The Department of Health and Children and the OECD² both publish estimates of Irish health expenditures – public and private – and these are presented in Figures 2.1 and 2.2 below (data is also presented in Annex I). Differences in the two sets of figures are usually explained as arising from the treatment of certain benefits, such as disability payments, that are paid through the Department of Health and Children, but which are not included in the OECD data. The OECD estimate of public expenditure is, therefore, lower and private expenditure higher than that of the Department, and its estimate of the private share of total expenditure is generally higher.
- 2.5 Up to 1997, there were relatively small differences between the two series for total expenditure (Figure 2.1), but somewhat larger differences in the public and private sector components (Figure 2.2). The data from 1997 to 1999 shows a strong growth in overall health spending (see Figure 2.1), and the private share falling steadily since the mid-1990s (see also Annex Table 2.1).

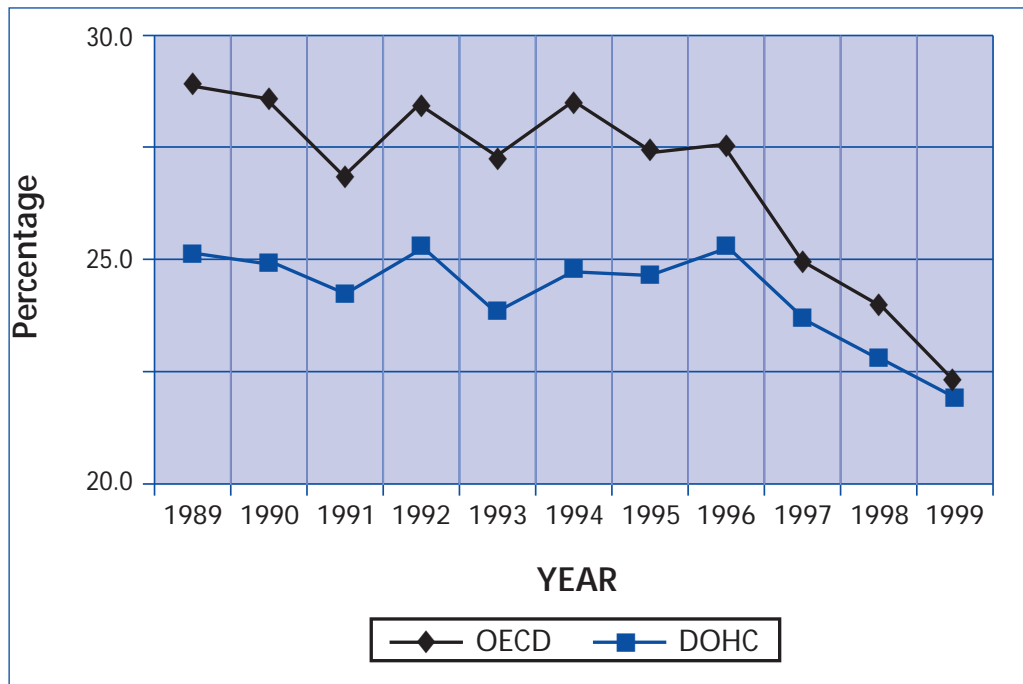
Figure 2.1 Total Health Expenditure (€m)



Source: OECD Health Data 2000; Health Statistics 1999 and more recent figures supplied by the Department of Health and Children.

2. All references to the OECD are to the OECD Health Data 2000, unless otherwise stated.

Figure 2.2 Private Share of Health Expenditure



Source: OECD Health Data 2000; Health Statistics 1999 and more recent figures supplied by the Department of Health and Children.

- 2.6 De facto equal access requires an equitable distribution of available health services over the population, based on need. While this principle of equitable distribution informs policy-making, it is nevertheless interesting to note that there is no formal mechanism for equitable resource allocation in our health system:

“Being incremental, the allocation process for health agencies is a system which may not be fully reflecting the needs of local populations in regard to health services. These needs may vary according to different demographic profiles and to morbidity but a formula for an allocation process which takes significant account of these factors is not in place” (DOHC 2001, p. 19).

- 2.7 Table 2.1 shows that, while health spending grew as a share of GDP in the early 1990s, from 1993 (OECD) or 1994 (DOHC) to the late 1990s it was outpaced by the very strong growth in the economy, such that it fell as a share of national income. According to the DOHC data, total health expenditure declined relatively from 8.2 per cent in 1992 to 7.2 per cent in 2000.

Table 2.1: Ireland – Expenditure on Health (% GDP/GNP) 1989 - 2000

Year	Total			Public		Private	
	OECD % GDP	DOHC %GDP	DOHC %GNP	OECD %GDP	DOHC %GDP	OECD %GDP	DOHC %GDP
1989	6.6	7.4	8.5	4.7	5.5	1.9	1.9
1990	7.0	7.2	8	5.0	5.4	2.0	1.8
1991	7.4	7.6	8.4	5.4	5.8	2.0	1.8
1992	7.8	8.2	9.2	5.6	6.1	2.2	2.1
1993	7.8	8.2	9.1	5.7	6.2	2.1	1.9
1994	7.7	8.2	9.1	5.5	6.2	2.2	2.0
1995	7.4	7.9	8.8	5.4	6.0	2.0	1.9
1996	7.2	7.5	8.4	5.2	5.6	2.0	1.9
1997	7.0	7.3	8.3	5.3	5.6	1.7	1.7
1998	6.4	7.0	8.0	4.8	5.4	1.6	1.6
1999	6.1	7.2	8.4	4.7	5.6	1.4	1.6
2000	n.a.	7.2	8.5	n.a.	5.5	n.a.	1.6

Source: OECD Health Data 2000; Health Statistics 1999 and more recent figures supplied by the Department of Health and Children.

2.8 Share of national income is understood as a comparison of national effort relative to resources. While it is standard practice in international comparisons to express health care expenditure as a percentage of GDP, this may not be appropriate for this country, given the unusually large differences between our figures for GDP and GNP. For example, Irish GDP was 11 per cent higher than GNP in 1994 and this gap grew steadily to 14.9 per cent in 1999. Table 2.1 also includes the Department’s estimates for health spending as a proportion of GNP, which show a broadly similar declining trend in relative health spending (from 9.2 per cent in 1992 to 8.5 per cent in 2000).

2.9 The Department of Health and Children’s spending Estimates, which is the main component of expenditure on health, show an increase in public spending on health in the last two years. For example, Net Voted expenditure for the Department, was €6,554.3 million in 2001, an increase of over one-fifth compared to 1999. These rates of growth far exceed (actual or expected) economic growth and the declining trend in the health share in national income have been reversed as a result.

2.10 A wide range of medical and social care services are included under the heading of health services. Table 2.2 presents a breakdown of the Department’s Voted

Expenditure by main Programmes.³ Overall expenditure, on this measure, more than doubled in nominal terms between 1994 and 2001, with considerable variation in the rate of growth across Programmes (Panel B). Thus, there have been some changes in the relative shares of different Programmes (Panel C). While private expenditure on health services is not apportioned in the same way in any of the available sources, such expenditure is, however, mainly for more narrowly defined medical services. This is made up of out-of-pocket expenditure – which goes mainly towards private GP services, pharmaceutical and public hospital charges – and private insurance payments which are largely in respect of acute hospital care (Nolan and Wiley, 2000:2).

Table 2.2: Gross Voted Non-Capital Expenditure by Programme, 1994 - 2001

	Community Protection	Community Health	Community Welfare	Psychiatric	Handicap*	General Hospital	General Support	All
<i>A: €m*</i>								
1994	51.0	471.8	254.8	274.0	282.9	1455.9	118.0	2908.6
1996	69.4	550.9	169.4	296.1	339.7	1620.8	136.6	3183.1
1998	99.9	687.2	285.6	347.5	436.7	1988.4	194.8	4040.0
2000	224.9	985.1	445.8	433.6	651.5	2604.5	264.9	5610.3
2001	291.7	1113.4	577.1	493.6	801.2	3243.6	304.5	6825.1
* figures may not add to total due to rounding.								
<i>B: Index</i>								
1994	100	100	100	100	100	100	100	100
1996	136	117	66	108	120	111	116	109
1998	196	146	112	127	154	137	165	139
2000	440	209	175	158	230	179	225	193
2001	571	236	226	180	283	223	258	235
<i>C: % Share</i>								
1994	1.8	16.2	8.8	9.4	9.7	50.1	4.1	100.0
1996	2.2	17.3	5.3	9.3	10.7	50.9	4.3	100.0
1998	2.5	17.0	7.1	8.6	10.8	49.2	4.8	100.0
2000	4.0	17.6	7.9	7.7	11.6	46.4	4.7	100.0
2001	4.3	16.3	8.5	7.2	11.7	47.5	4.5	100.0

Source: Annual Estimates Volumes.

* The term 'Handicapped Programme' is the Department's.

3. Details of the services included in each Programme are provided in the Annual Estimates Volume.

Private Health Insurance

- 2.11 In practice, most private hospital treatment is covered by private health insurance rather than paid for out-of-pocket. Table 2.3 presents data on private health insurance cover from 1979. It records exceptionally strong increases at the beginning of the period and then relative stability for a number of years in the mid-1980s. There was a renewed expansion in the year to February 1988 and coverage grew fairly strongly each year thereafter. The rate of increase clearly accelerated in the latest years shown here. This is due to a range of factors such as waiting lists and quality of service in the public hospital system, rising living standards, many more people employed, people's demands for more healthcare and the rise in employer purchase of health insurance as part of employees remuneration packages.
- 2.12 Apart from some small schemes, private health insurance here had its origins in the setting up of the Voluntary Health Insurance Board in 1957. The VHI was established as a statutory non-profit monopoly to provide affordable health insurance for the population (15 per cent) with no eligibility to public care. This insurance was provided on the basis of community rating, open enrolment and lifetime cover. Under community rating, premiums are set with reference to the total risk pool rather than on the basis of individual risk-rating. Similarly open enrolment (anyone who can meet the premium cannot be refused cover) and lifetime cover (insurers cannot refuse to renew an insurance contract) are essentially means to prohibit risk selection by insurers.
- 2.13 The VHI's monopoly situation ended with the Health Insurance Act 1994 which implemented the EU Third Non-Life Directive 1994 in this country. Since then the private health insurance market has been open to competition. To-date, BUPA Ireland is the only new company to establish here and it holds around 4 per cent of market share. Regulations under the Act require that the main elements mentioned above of the established health insurance framework – community rating, open enrolment and lifetime cover – continue to apply. Even so, and with more than one insurance firm now operating here, the possibility arises that there may be competition for market share on the basis of (intentional or unintentional) selective recruitment. However, Government policy is to discourage such competition through the introduction of some measure of risk equalisation.
- 2.14 In the 1999 *White Paper on Private Health Insurance* the Government indicated that it intended moving to Lifetime Community Rating. This would mean that – unlike the Standard Community Rating system now in place – different premiums could be charged depending on age when taking out insurance. This would provide an incentive for people to take out insurance at a younger age and to maintain consistent coverage. Lifetime Community Rating has been advocated here and elsewhere as a solution to the problems of adverse selection

that are seen as intrinsic to a voluntary Community Rating system. Such Rating is a form of risk sharing and premiums reflect the average experience of the pool. In principle, this will be more attractive to people of above average risk and less attractive to others.

Table 2.3: Private Health Insurance Cover, 1979 - 2001

Year (February)	Number Insured 000	Annual Increase %	Population Coverage %
1979	735		21.8
1980	888	20.7	26.1
1981	986	11.1	28.6
1982	1051	6.6	30.2
1983	1082	3.0	30.9
1984	1099	1.6	31.2
1985	1106	0.6	31.2
1986	1107	0.1	31.3
1987	1113	0.5	31.4
1988	1155	3.8	32.7
1989	1185	2.6	33.8
1990	1207	1.9	34.4
1991	1245	3.1	35.3
1992	1274	2.4	35.9
1993	1303	2.3	36.5
1994	1337	2.6	37.3
1995	1364	1.9	37.9
1996	1393	2.1	38.4
1997	1435	3.0	39.2
1998	1500	4.5	40.5
1999	1567	4.5	41.8
2000	1658	5.8	43.8
2001	1760	6.1	46.2

Source: Department of Health and Children.

2.15 Private insurance has been and continues to be promoted through a range of public subsidies. These include tax relief on premiums – initially at the taxpayers

marginal rate – but this has been reduced to the standard rate in stages between 1994 and 1996. This change, combined with the general reduction in tax rates, has reduced the individual value of this relief as a share of the premium. However, it still cost €79 million in 1998/1999. Retention of this relief is stated Government policy.

- 2.16 In addition, the cost of private claims and thus insurance premiums have been deliberately kept lower than would otherwise be the case by applying lower (below cost) charges for private accommodation and services in public hospitals. One of the main findings of a recent study of this issue is that the charges levied may only cover around half the direct cost of private provision (Nolan and Wiley, 2000) and stated Government policy is to move to full economic cost charging based on Diagnostic Related Groups.

Health Services Delivery

Public Provision of Health Services

- 2.17 Public provision of healthcare in Ireland developed incrementally as different services were made available selectively over time, largely to those who could not afford them. Before 1953, public provision of most personal medical services was restricted to the poorest section of the population in the form of ‘medical assistance’ with the (significant) exception of public health services – including the treatment of infectious diseases – which were provided for everyone without charge. Public provision was supplied directly by local authority health agencies, with some more complex medical treatments supplied by/purchased from voluntary hospitals. Limited medical benefits were provided for some of the insured population under National Health Insurance, and everyone else relied on private means or charity. However, increasingly charity – in the form of the voluntary hospitals – came to be ‘publicly’ subsidised through the Hospitals Trust Sweepstakes.
- 2.18 The Health Act, 1953 introduced a three-category eligibility structure for public health services. It made public hospital and specialist services (but not GP services) available to a large middle-income group, with statutory charges. Some 15 per cent of the population with higher incomes were not publicly covered and the Voluntary Health Insurance Board (VHI) was set up in 1957 to provide insurance for this group and others who wished to take it up.
- 2.19 Over time, eligibility for public hospital and specialist services were extended to the higher income group, on the same basis as those on middle incomes. In 1979, they became eligible for public hospital accommodation and in 1991 they became eligible for public hospital consultant services.

- 2.20 Since then everybody ordinarily resident here, normally for a minimum period of one year, are classified into two eligibility categories. This is largely based on family income (although recently the Government decided to extend full eligibility to all those aged 70 or more regardless of means.). **Category 1** – i.e. those who satisfy the means test or other criteria for holding a medical card – are deemed to have full eligibility for a comprehensive range of publicly-provided health services including general practitioner services, prescribed drugs and medicines, all in-patient public hospital services in public wards including consultant services, all out-patient public hospital services including consultant services, dental, ophthalmic and aural services and appliances and a maternity and infant care service.
- 2.21 The latest figure available for end-September 2001 show that 1.2 million people, representing over 30 per cent of the population, were covered by the GMS (medical card). This proportion had fallen from 36 per cent in 1994 to under 30 per cent in April 2001, but has since increased (Dáil Éireann 5 December).
- 2.22 All other residents who do not qualify for a medical card (**Category 2**) are eligible for some but not all public health services. Subject to certain charges, they are eligible for all in-patient public hospital services in public wards including consultant services and out-patient public hospital services including consultant services. A maternity and infant care service is provided during pregnancy and up to six weeks after birth. Alongside this general eligibility structure, people may qualify for certain medical benefits under Pay Related Social Insurance (PRSI) where entitlements depend on one's PRSI contribution record.
- 2.23 A decade ago the OECD described the public financing of health care in this country as "*an example of the social assistance model*" (OECD, 1992:73). This characterisation accurately describes the historical evolution of all public medical services here and, as we have seen, it continues to directly apply to the provision of general medical services. A more complex picture holds for (acute) hospital care. Since 1991, there has been universal public coverage for hospital and specialist services. Anyone normally resident here is entitled to full care in public beds in public hospitals regardless of means. Those with full eligibility receive these services without charge. People in Category 2 are liable for general statutory charges for these services such as admission to accident and emergency and daily in-patient fees.
- 2.24 We turn now to consider the public-private mix in the delivery of:
- General Medical Services; and
 - Hospital and Specialist Medical Services.

Delivery of General Medical Services

- 2.25 Public general medical services are supplied directly by Health Boards and, in some cases, are purchased from private professional suppliers.
- 2.26 Health Boards directly employ health professionals – public health doctors and nurses, dentists, etc. In the main, these supply public health and community health services – such as school health services – that are made available without charge to the population as a whole. In addition, medical cardholders' entitlements to dental treatment are partially met in this way.
- 2.27 Before 1970, general personal medical services to those in Category 1 were provided by salaried dispensary doctors but now most of these services are purchased from private professional suppliers. These include: General Practitioner, Pharmacy, Dental and Optometric/Ophthalmic services. In addition, some other services not restricted to Category 1 – such as primary childhood immunisations – are purchased in this way. In practice, the purchase of these services is carried out at a national level through the General Medical Services (Payments) Board. Provision is organised through a range of service specific schemes (General Medical Services/Choice of Doctor Scheme, Health Board Community Ophthalmic Services, etc.), which set out the entitlements of patients and the contractual arrangements with suppliers.
- 2.28 As noted earlier, the majority of the population has only partial eligibility (Category 2) and must, therefore, purchase most general medical services privately. However, private expenditure on these services does attract direct and indirect public subsidy.
- 2.29 Direct subsidies include the refund of approved drug costs in excess of a given amount (currently €53.33 per calendar month) through the Drug Payments Scheme that is also organised by the General Medical Services (Payments) Board. In addition, under the Long-Term Illness Scheme those suffering from a number of conditions can obtain drugs and medicines without charge. Indirect subsidy is provided through the tax system. Tax relief may be claimed on most household expenditure on healthcare in excess of a given amount (currently €127 for a single person and €254 for a family) in any tax year. Such relief is available at a claimant's marginal rate and cost €31.4 million in foregone revenue in 1998/1999.

Delivery of Hospital and Specialist Medical Services

- 2.30 Public hospital services are provided in Health Board hospitals and in publicly-funded voluntary hospitals. In 1999, out of 12,292 beds in acute public hospitals, 7,241 (58.9 per cent) were provided in Health Board hospitals and 5,051 (41.1 per cent) in voluntary hospitals (Nolan and Wiley, 2000). Most voluntary

hospitals are concentrated in Dublin, with smaller numbers in other major cities. Health Board hospitals are owned and administered directly by the Boards. Voluntary hospitals are operated by religious orders and/or lay boards of governors. While these hospitals are legally private, they operate as an integral part of the public system and for our purposes here we treat them as public suppliers.

- 2.31 Public hospital medical services – including specialist services – are directly supplied by the hospitals staff. At January 2001, there were 4,798 doctors employed in Health Board and public voluntary hospitals. This included 1,560 consultant posts and 3,238 Non-Consultant Hospital Doctors (NCHDs), giving an overall Consultant to NCHD ratio of 1:2.1 (Forum on Medical Manpower, (FMM), 2001). This ratio, which is disproportionately high compared to the private sector (where only 35 NCHD are employed), varies across specialities. It was close to 1:3 in Medicine, Surgery and Obstetrics/Gynaecology and was 1:9.9 in Accident and Emergency (FMM, 2001: Table 1 page 21).
- 2.32 As we have mentioned earlier on, most publicly-provided general medical services are purchased from private suppliers. To-date, this approach has played a much more ad hoc role in regard to hospital or specialist services. However the Government’s new Health Strategy envisages the development of “*closer strategic links with the private hospital sector*” (p.94) in order to improve access to treatment for public patients (see Section VII below).
- 2.33 While there is universal coverage for public hospital services in this country, there is also a relatively large-scale private provision of acute hospital and consultant services. There is no specific public regulation of the private hospital sector and, as a corollary, few requirements for public disclosure of data, with the result that information on this sector is limited.
- 2.34 Private hospitals supply an estimated 2,500 acute (overnight and day) beds. Only elective procedures are carried out in these hospitals and they have no Accident & Emergency Departments. Private treatment is also supplied in public hospitals. Of 12,292 acute beds in the public system in 1999, 2,528 were designated for consultants’ private patients. These comprised 20 per cent of overnight beds and 32 per cent daybeds and were evenly distributed across Health Board and voluntary hospitals (White Paper, 1999: 12; Nolan and Wiley, 2000: 16-17). Total private beds (5,028) accounted for approximately 34 per cent or one-third of all acute hospital beds.
- 2.35 While no comprehensive data is available, it is estimated that the private hospital sector accounts for 250,000 admissions per annum (DOHCB, 1999:9). The public acute hospital system accounted for 870,000 admissions/discharges in 2000, but this does not distinguish between public and private patients. However,

the Hospital Inpatient Enquiry indicated that 23.5 per cent of public hospital discharges in 2000 were private (Wiley 2001:83). Applying this ratio to the figure for total admissions in that year gives us an estimated 204,450 private admissions. Taking this, together with the earlier estimate of 250,000 private hospital admissions, we can crudely estimate that private admissions accounted for around 40 per cent of total acute admissions.

- 2.36 Again comprehensive data is also not available on the private caseload. However, we have seen above that the share of private admissions exceeds the private share of beds. In addition, the occupancy rate in private hospitals is reported to be significantly lower than that of the public system (Armstrong, 2001). This indicates that the average duration of stay is lower among private patients, which suggests that the private caseload is less complex on average than the public and this is generally agreed to be the case.
- 2.37 Our estimates above suggest that around 45 per cent of private admissions are to public hospitals. This is broadly consistent with the Forum on Medical Manpower's suggestion that half of the private care is provided in public hospitals (FMM 2001:20). However, this underestimates the public sector's relative role as a supplier of private medical care as public hospitals provide "*significantly more than half of the complex private caseload*" (ibid: 20).
- 2.38 Medical services in the private hospital sector are almost entirely consultant delivered. It is estimated that the private sector employs approximately 35 Non Consultant House Doctors (NCHDs) (FMM, 2001:20). Consultants supply services to private patients – in both private and public hospitals – as independent contractors on a fee for service basis. An estimated 155 consultants work exclusively in private practice. Most consultants in private hospitals also hold salaried public hospital consultant posts. They have a greater incentive to treat more private patients, as they are paid a fee-for-service for these patients. In this regard, Professor Dale Tussing has argued in favour of altering the incentive structure so that consultants would "*be paid in the same manner for public and private patients*" (Tussing, 2001: 9).
- 2.39 Consultants in publicly-funded hospitals are employed under contracts that specifically allow for both public and private practice. These contracts are of two main types, which distinguish between those for whom the option of private practice is limited to practice within public hospitals (Category 1) and those who may also practice in private hospitals (Category 2). Of 1,560 public hospital consultant posts at January 1991, 53 per cent were Category 1 and 37 per cent were Category 2.⁴ The Eastern Regional Health Authority (ERHA) area accounts for most Category 2 posts (74.9 per cent). This represents 57.7 per cent of the 750 posts in the ERHA area (Comhairle na nOspíéal, 2001).

2.40 All public hospital consultants are contractually permitted to treat private patients in the public hospital(s) where they are employed. It is generally recognised that consultants play a more direct role in the treatment of their private patients in public hospitals than in that of their public patients.

Conclusions

2.41 The public-private mix in the financing and delivery of health services in this country, which is central to concerns about a 'two-tier' system, has certain key features that were highlighted in this Section of the Report. About 30 per cent of the population are eligible for free health services across the board, including in acute public hospitals, on the basis of income – that is, they are covered by a 'medical card'. The rest of the population are now also entitled to care in public beds in public hospitals, subject to some statutory charges. Those who are in a position to pay – generally covered by health insurance – can however avail of private care.

2.42 Reflecting the way the public-private mix evolved, a large part of privately-financed specialist care is supplied by consultants who also hold public hospital salaried contracts, and in many cases this is supplied in public hospitals. About half of all private beds are in public hospitals, and these comprise about one-in-five of all beds in acute public hospitals. This 'public' supply of private hospital and specialist services is a specific characteristic of the 'two-tier' health care in this country and the way it came about is discussed further in Section IV below. First though, Section III places our public-private mix in a comparative perspective, with the emphasis on highlighting its unusual features.

4. The balance included those who are full-time in public hospitals, without fees, and those on academic contracts.

Section III

International
Perspective

Section III: International Perspective

Introduction

- 3.1 The previous Section outlined the structure of our healthcare system, with particular emphasis on the complex interaction of public and private elements, especially in hospital care. We go on in this Section to look at this public-private mix in a comparative context, particularly in relation to our European Union partners. All health systems mix public and private elements, but not always in the same way or to the same extent, and thus issues of equity of access may arise in quite different structural contexts.
- 3.2 The comparative perspective is important because it allows us to see the extent to which Ireland's structure is unusual compared with other countries. It also allows us to see the variety of structures through which healthcare can be organised and delivered, with the structure that has evolved over a long period in Ireland just one possibility.

Health Spending in Comparative Perspective

- 3.3 The OECD compiles comparative data on health expenditure. However, the development of internationally comparable health accounts is at a relatively early stage and all these comparisons carry a standard warning about the reliability of the data. We focus here on data regarding the Member States of the EU.
- 3.4 Table 3.1 below shows data on total health spending and public and private shares for EU countries in 1998. In that year, Ireland spent 6.4 per cent of its GDP on healthcare, compared to an unweighted EU average of 8 per cent. The variation in country spending on this measure is quite wide and has grown in recent years as the highest spenders have increased spending. It will be noted that Germany (10.6 per cent) and France (9.5 per cent) are particularly high spenders. At the other end of the scale, Luxembourg (5.9 per cent) and Ireland (6.4 per cent) are at the bottom of a group of five low spenders, which also included the UK (6.7 per cent), Finland (6.9 per cent) and Spain (7.1 per cent).

Table 3.1 Health Expenditure in EU Countries, 1998 (% GDP)

	GDP Total %	Public Share	Private Share
Germany	10.6	74.5	25.5
France	9.5	75.8	24.2
Belgium	8.8	89.8	10.2
Netherlands	8.6	69.8	30.2
Italy	8.4	66.7	33.3
Sweden	8.4	83.3	16.7
Denmark	8.3	81.9	18.1
Greece	8.3	56.6	43.4
Austria	8.2	70.7	29.3
Portugal	7.8	66.7	33.3
Spain	7.1	76.1	23.9
Finland	6.9	76.8	23.2
U.K.	6.7	83.6	16.4
Ireland	6.4	75.0	25.0
Luxembourg	5.9	91.5	8.5
EU Average	8.0	75.6	24.4

Source: OECD, 2001.

3.5 For a number of reasons, this comparison should, however, be treated carefully. Firstly, Irish expenditure was generally closer to the EU average in earlier years and the fairly sharp fall in the share of health expenditure in GDP in recent years has to be seen in the context of the significantly higher economic growth rates here. Secondly, while it is standard practice in international comparisons to express healthcare expenditure as a percentage of GDP, this may not be appropriate for Ireland (see the earlier discussion in Section II). For example, using GNP as the denominator would add about 1 per cent to Ireland's spending ratio, but would have little effect in most other EU countries. On the basis of this measure, we would be closer, therefore, to the EU average and ranked somewhat higher. Finally, exceptionally large increases in spending in the most recent years will have reversed the relative decline in Irish health expenditure as a share of national income however measured, despite continuing high economic growth over the period. This also means that our position relative to other EU countries should have improved.

3.6 Turning to the public-private mix in health spending in 1998, the share of private spending in Ireland's total spending (25 per cent) was close to the EU average of 24.4 per cent, along with Germany, France, Spain and Finland. (As we

saw earlier, Ireland's private share has probably fallen somewhat in the last few years). The share of private finance was below the EU average in Sweden, Denmark, the UK, and exceptionally so in Belgium and Luxembourg. On the other hand, private finance plays a somewhat bigger role in the healthcare systems of Austria and the Netherlands, accounting for one-third of total expenditure in Italy and Portugal and 43 per cent in Greece.

The Role of Private Finance

3.7 In considering the above comparisons, it is important to look at what private finance actually does and how this differs across countries. In the UK, for example, the Kings Fund (2001) (one of the leading health think tanks there) has estimated the breakdown of private health finance as follows:

– over the counter medicines	41%
– private medical insurance	17%
– NHS user charges	13%
– out-of-pocket hospital care	8%
– optical services	8%
– complementary	7%
– dentistry	5%
– audiology	1%

This breakdown is not presented as typical – indeed, it is known that the private insurance share of private financing varies considerably across countries and we discuss this below. The point is simply that private health finance covers a wide range of goods and services, other than acute care.

3.8 In addition, as we saw earlier, 'private finance' cannot be simply equated with private provision of health services as we have defined this term. Some private expenditure – whether out-of-pocket or through private insurance – supports public provision in the form of charges or co-payments. In many EU countries co-payments play a relatively larger role compared to Ireland. For example, the higher private share in health financing in Finland, compared to the other Nordic countries, reflects higher co-payments for public services rather than a larger private sector. Thus, while Ireland and Finland have similar levels of health spending and private shares, in practice private healthcare plays a much more limited role in Finland than in Ireland.

3.9 In order to clarify the issues here from the perspective of equity of access, we have adopted the following typology of healthcare financing as provided by Hurley (2001:236):

- 1 fully private financing through private insurance purchases and direct payments by patients to providers;
 - 2 public subsidies to support the purchase of insurance in private markets, and /or public insurance for certain population sub-groups;
 - 3 universal publicly-financed insurance, with a parallel private insurance sector offering coverage for the same services insured by the public sector; and
 - 4 universal publicly-financed insurance with no parallel private insurance sector.
- 3.10 Type 1 is fully privately financed. At the other extreme, Type 4 is ‘fully public’, though it is important to be clear what is meant in this case. It is not that all health services, however defined, are fully publicly-financed. In no country is **all** healthcare publicly financed in full. Rather it is that some significant/essential part of medical services – in practice, incorporating but not limited to acute hospital services – is fully publicly financed. Types 2 and 3 are mixed systems with both public and private financing of essential services. The distinction between them is that in Type 2 public coverage is selective i.e. not all of the population is publicly covered, while in Type 3 it is universal.
- 3.11 No health system in the developed world could be classified as Type 1. Essentially in this model access to healthcare would be a simple function of ability to pay. Hurley cites the USA as exemplifying Type 2. There, the mainly private marketplace for healthcare is supplemented with selective public insurance for older people (Medicare) and some – but not all – of those who are poor (Medicaid) and some public and charitable provision. For many people without public cover – who are either low income or high risk or both – private insurance is unaffordable. Thus large numbers remain without health insurance and as a result access to essential healthcare is highly inequitable (Institute of Medicine, 2001).
- 3.12 What is less clear is whether a system without universal public coverage is *necessarily* inequitable, or at least so inequitable as the US. Obviously, such systems may vary significantly in terms of the structure and extent of public coverage and the proportion of the population so covered. In principle, coverage gaps in the US system could be addressed by a wide range of possible reforms (ESRI; 2001), though all such reforms would require an increased role for public-finance and regulation. In the Netherlands⁵, for example, which excludes the top one-third of the population (by reference to income criteria)
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5. The case of Switzerland is frequently cited as a private insurance system that effectively achieved universal private coverage through a combination of regulation and subsidies. However, the Swiss system defies easy classification in the schema outlined above as it combines features of private and social insurance and, in recent years, has made medical insurance compulsory.

from public coverage for some risks – including acute care – access to healthcare is clearly much more equitable than the US. The Netherlands is an exceptional case. According to Keen *et al* “*nowhere is private health insurance so fully integrated into the social goals of the overall system and plays so little of its typical role as a second-tier upgrade for the better-off*” (2001:134).

- 3.13 Hurley cites the UK as exemplifying Type 3 and this is also where Ireland fits. This configuration is inherently ‘two-tier’. In it, and despite universal coverage, ability to pay is translated into faster access and/or better services. If private finance did not deliver these it would not be a very popular option, as it would mean in effect that people would be paying twice for the same cover. Hurley cites the Canadian healthcare system as exemplifying his fourth Type. The Canadian system is strongly egalitarian and effectively prohibits private insurance for the benefits covered by the universal public Medicare system i.e. hospital and physician services. Other medical services, (such as pharmaceuticals, dental care, etc.) are financed by a mixture of public and private sources.
- 3.14 A recent study of voluntary health insurance in the EU (Mossialos and Thomson, 2001) gives some indication of how this classification might be applied to EU countries. This classifies private insurance “*according to whether it substitutes for the statutory healthcare system, provides complementary cover for services excluded or not fully covered by the State, or provides supplementary cover for faster access and increased consumer choice*”⁶. In our typology, substitutive insurance by definition applies to Types 1 and 2. Private insurance can play a complementary role in all of the models. Both Types 3 and 4 include universal public coverage, but they differ in the role of private insurance. Supplementary or parallel insurance is by definition excluded from Type 4 and included in Type 3.
- 3.15 In most European systems, where there is universal public provision of essential services, parallel private financing of these services remains an option. According to Mossialos and Thomson, “*In every EU member state it is possible for individuals to be covered by complementary or supplementary VHI in addition to statutory coverage*” (2001:9). In practice, EU countries vary enormously in the extent and nature of private health insurance but “*apart from countries where VHI plays a substitutive role – Germany, Netherlands and Spain⁷ – the take up of VHI tends to be fairly low and/or largely reflects coverage in co-payments for public services*”. In other words, it is largely complementary as defined here.
- 3.16 Thus, while the Canadian system is exceptional in explicitly restricting private insurance to a complementary role, in practice at least some EU countries – for

6. Although they go on to note that the distinction between complementary and supplementary VHI is not always clear and in some EU Member States there may be significant crossover between them.

7. We noted earlier that the Netherlands does not have universal public insurance for acute hospital care. Both Spain and Germany do, but they allow certain higher income groups to opt out of the public insurance scheme.

example France and Belgium – can also be effectively classified as Type 4 – i.e. acute hospital services are effectively publicly provided in full.

- 3.17 Parallel private financing of acute hospital services, as we know it in Ireland – seems to play a role only in a relatively small number of countries such as the UK, Australia and ourselves. According to OECD (2001) “*In other countries with an overwhelming public financing and providing system such as the UK, Sweden, Norway, Finland and Portugal, private health insurance represents a small market covering currently less than 10 per cent of the population and insuring mainly access to private providers*”. While all these countries have elements of a ‘two-tier’ system, what is most notable from an Irish perspective is how limited a role parallel private acute healthcare plays in most cases. In Norway, for example, the private hospital sector provides only around 1 per cent of hospital beds and 5 per cent of outpatient services (European Observatory on Health Care Systems, 2000:40). In the UK about one in eight of the population is covered by private health insurance and around 14.5 per cent of elective admissions are private (Williams, 1999).
- 3.18 Beyond the EU, parallel private insurance on a scale comparable to Ireland can be found in Australia. Indeed, Australian practice has informed a number of recent Irish policy developments in this area. Before the introduction of universal public health insurance in 1975⁸, Australia relied on publicly-subsidised private community rated health insurance, which in that year covered around four-fifths (78 per cent), of the population. This had fallen to a low of 30.1 per cent by the end-1998. The Coalition (centre right) Government in power since 1996 has strongly promoted parallel private insurance, most notably by providing a 30 per cent rebate on premiums, levying a surcharge on higher income earners who do not take out private insurance, introducing Lifetime Community Rating and promoting ‘no gap’ schemes to reduce unpredictable out-of-pocket payments.
- 3.19 As of September 2000, some 45.8 per cent of the Australian population was covered by private insurance. This aggressive promotion of private insurance has raised equity concerns. According to John Deeble, one of the founders of universal health insurance in Australia, “*Rhetorically, the emphasis has been on the competitive independence of private insurance, with a shift in its depiction from being supplementary to Medicare to being first a **complement** and then, most recently, an **alternative** to it. This is the thrust of the present recruitment campaign however obliquely expressed. The purchase of advantage is recognised and an explicitly two-tier system encouraged by such devices as the levy surcharge on higher income earners and the portrayal of private insurance membership as a civic duty which assists the poor*” (Deeble, 2000:46).

8. The initial Medibank programme introduced in 1975 underwent numerous changes and was abandoned in the early 1980s. The current Medicare scheme was introduced in 1984.

3.20 Ireland also is unusual in the level of public subsidisation of parallel private care:

“Although some countries provide significant tax incentives to individuals and insurers to encourage the expansion of VHO, in the majority of EU member states the trend has been to reduce or remove tax incentives. As a result there is no tax relief for VHI in Belgium, Denmark, Finland, France, Sweden and the United Kingdom, and only very limited tax relief in Germany and the Netherlands” (Mossialos and Thomson, 2001:1).

Private Treatment in Public Hospitals

3.21 As we saw earlier, Ireland promotes parallel private healthcare by supplying private services in public hospitals. In many countries, doctors typically operate as private businesses supplying services to both public and private providers (public agencies, public and private insurers, private individuals), much as general practitioners do in this country. Elsewhere, doctors – especially in hospitals – may be salaried employees. Ireland is not the only country where salaried doctors may also engage in private practice outside their public contract. This is also possible, for example, in the UK and in Finland.⁹

3.22 In the overall, as we have already noted, private provision (as distinct from private supply – see Section II) is less extensive in most European countries. However, the Irish arrangement where private practice is part of hospital consultants’ public contracts and carried out within the public hospital seems to be very unusual. While most countries do not provide private services in public hospitals, some – such as the UK and Australia – do so. However, closer examination of these countries’ arrangements confirm the exceptional nature of Irish practice in this area.

United Kingdom

3.23 In the UK, as in Ireland, acute hospital provision had its origins in the voluntary hospital movement with its system of honorary consultants on the one hand and the development of a local authority salaried hospital service on the other. In 1948, these were brought together under public ownership in the National Health Service (NHS) with a common salaried consultant establishment, which contractually allowed for parallel private practice and for the continuation of paybeds within NHS hospitals. However, the vast majority of NHS consultant’s private practice take place outside NHS hospitals.

3.24 In 1998, there were approximately 3,000 private beds in acute NHS hospitals in England and Wales, out of a total of 116,000 beds. However, even this figure

9. In Finland four out of five doctors working in the private sector have a post in the municipal i.e. public sector too (Ministry of Social Affairs and Health (2001) *“Trends in Social Protection in Finland 2000-2001”*: p.110).

overstates effective private provision. Some 1,400 beds were in 75 dedicated private patient units and the remaining paybeds were distributed in ordinary wards. These were also available to NHS patients and their private patient occupancy was estimated at only 10 per cent.

3.25 The most recent data (for the year to 1 April 2001) show that private patients accounted for just 1 per cent of total NHS admissions. These were all elective admissions, accounting for just over 2 per cent of the elective total (DOH Statistical Press Notice: 16 November 2001).

3.26 While the scale of private provision does not compare at all then with the Irish case, paybeds are still seen as posing a problem for equity within the NHS (Keen *et al*, 2001). The management of private practice in NHS hospitals is formally governed by guidelines dating from 1985. These guidelines set out the following six principles to be observed by consultants in using NHS service facilities for private patients:

- the provision of accommodation and services for private patients should not significantly prejudice non-paying patients;
- subject to clinical considerations, earlier private consultation should not lead to earlier NHS admission or earlier access to NHS diagnostic procedures;
- common waiting lists should be used for urgent and seriously ill patients, and for highly specialised diagnosis and treatment; the same clinical criteria should be used for categorising paying and non-paying patients;
- after admission, access by all patients to diagnostic and treatment facilities should be governed by clinical considerations; this does not exclude earlier access by private patients to facilities especially arranged for them if these are provided without prejudice to NHS patients and without extra expense to the NHS;
- standards of clinical care and services provided by the hospital should be the same for all patients; this does not affect the provision, on separate payment, of extra amenities, nor the custom of day-to-day care of private patients usually being undertaken by the consultant engaged by them; and
- single rooms should not be held vacant for potential private use longer than the usual time between NHS patient admissions.

Nevertheless, the available evidence suggests that private patients do get faster access to NHS hospitals (Williams, 1999).

Australia

- 3.27 Australia's compulsory universal health insurance system – known as Medicare – is financed from general taxation and a dedicated levy. It funds free access to public hospitals and subsidises medical services and pharmaceuticals for everybody. Out-of-hospital medical services, such as GP care, are reimbursed at 85 per cent of a government set fee, subject to a ceiling.¹⁰ Private health insurers (health funds) are not permitted to provide any benefits for medical treatment provided outside of hospital for which a Medicare benefit is payable. Medicare benefits for in-hospital treatment differ between public and private patients. Public patients in public hospitals are treated by doctors appointed by the hospital without charge. Private patients (whether in a public or a private hospital) receive a flat rate benefit of 75 per cent of the set fee, and are responsible for meeting the remainder of the doctor's fee and hospital charges, which may be met by out-of-pocket or through private insurance.
- 3.28 In the federal system, State and Territory Governments are responsible for ensuring the provision of public hospital services free of charge to public patients on the basis of clinical need, regardless of geographic location. Doctors may be employed by public hospitals, on either a salaried or sessional basis for the treatment of these patients.
- 3.29 Admitted patients elect to receive public hospital services as either public or private patients. A private patient is defined as an eligible person who elects to be responsible for paying fees that are determined by the State Government. They can choose their doctor, provided that the doctor has visiting rights at the hospital. Where a patient receives care in a public hospital on a fully-private basis, the treating doctor can charge for the service and Medicare benefits are payable. Such care must be provided outside any contractual Visiting Medical Officer session, where the doctor is being remunerated by the hospital to treat public patients.
- 3.30 In 1997-98 private patients accounted for 9.5 per cent of public hospital discharges, compared with 16.5 per cent in 1993-94. One factor in this decline is that private patients are increasingly opting for private hospitals to avoid longer waiting times in public hospitals. Public hospitals accounted for 36 per cent of privately-insured discharges in 1993-94 but just 19 per cent of such discharges in 1997-98 (Productivity Commission, 1999:5).
- 3.31 The Australian system for admitting private patients to public hospitals is very different to our system. Firstly, as we saw, in Australia there is no distinction between public and private patients for out-of-hospital medical services – all are

10. Doctors may – with the patient's agreement – directly bill Medicare rather than bill the patient, but in this case they must accept the Medicare payment as full settlement.

covered by Medicare and private insurance is prohibited. Secondly, patients are treated on the basis of clinical need and not on whether they elect to be treated as a public or private patient. Thirdly, public hospitals maintain a single waiting list for elective surgery and doctors classify all patients into one of three urgency categories according to the following agreed national definition:

Category 1 – admission within 30 days desirable, condition has the potential to deteriorate and may become an emergency;

Category 2 – admission within 90 days desirable, condition causing some pain, dysfunction or disability but unlikely to deteriorate quickly or become an emergency; and

Category 3 – admission at some time in the future acceptable, condition causing minimal or no pain, etc., unlikely to deteriorate quickly or to become an emergency.

Conclusions

- 3.32 While a comprehensive comparison is beyond the scope of this Section, the evidence discussed here shows clearly that our public-private mix is quite distinctive, particularly in a European context. In this country, and despite universal public coverage for acute hospital services, close to half the population is covered by private medical insurance; this is to a large extent supplementary in the sense we are using that term here i.e. it is for faster access and a (real or perceived) higher quality of services than are publicly-provided on a universal basis.
- 3.33 In other countries with a universal publicly-financed system, parallel private financing through private health insurance generally plays a much smaller role than it now does in Ireland. Secondly, the extent to which delivery of public and privately-financed care are interconnected rather than separated is considerably greater than in other such healthcare systems. This means that the scope for ‘two tiers’ in terms of access to public hospitals is much greater here than in, for example, our European Union partners. The implications of this for equity of access in our system are the central focus of this Report, and developed in subsequent Sections.

Section IV

Public-Private Mix and Equity of Access

Section IV: Public-Private Mix and Equity of Access

Introduction

- 4.1 If the public-private mix in public hospitals in Ireland is indeed unusual in international perspective, how did it come about and what does it mean for equity? This Section first looks at the way private practice in public hospitals evolved over time in Ireland, which is essential to understanding the role it plays. The Section then turns to how the implications of this public-private mix for equity of access have been viewed in public policy terms, particularly since concerns about a 'two-tier' system came to the fore in the 1980s.

Development of Private Practice in Public Hospitals

- 4.2 As noted earlier, the Irish public hospital system includes local authority/health board and public voluntary hospitals. Voluntary or charitable hospitals developed in the 18th and 19th centuries to cater for those who could not privately engage specialists at home. In these hospitals, patients were initially treated free in shared 'public' wards (public patients). As hospital medicine developed, the voluntary hospitals offered their services to a wider segment of the population who were charged for maintenance according to their means.
- 4.3 Throughout most of their history, visiting hospital doctors or 'consultants' appointed by the voluntary hospitals were not directly paid for treating the public patients of these hospitals. With the development of hospital medicine, particularly in the first half of the 20th century, the practice of allowing consultants use private beds and other hospital facilities for their private patients in return for their services to the hospitals 'public' patients emerged. The extent of this practice in Irish voluntary hospitals in these earlier years is difficult to determine. However in the early 1960s, twenty-six voluntary hospitals in Dublin city together had 4,885 beds of which 13 per cent were private or semi-private. (Dáil Éireann Vol 219, 24 November 1965, PQ on Dublin Voluntary Hospitals).
- 4.4 The Health Board hospital system originated with local authority responsibilities for medical assistance and for public health. From the 1920s, senior hospital specialists in this system were employed on a salaried basis through the Local Authorities Commission. Specialists employed in the local authority medical services had limited private practice rights which typically allowed each specialist

the use at any one time of not more than four beds for the treatment of private patients (Dáil Éireann Vol. 244, 11 February 1970, PQ on Surgeons' Remuneration). As the total number of local authority specialists was small – in 1964, for example, local health authorities employed only 145 specialists and were not allowed private practice – the private bed complement in local authority hospitals could not have been very large, and certainly accounted for a lower share than in the voluntary hospitals.

- 4.5 Over time charitable financing of the voluntary hospitals declined and was replaced by patient payments and public funds. The Health Act, 1953 extended public provision of hospital and specialist services (but not GP services or other health board services) to a large middle-income group. This legislation specified that consultants in voluntary hospitals could be paid for treating publicly-funded patients and this became the norm in subsequent years.¹¹ Consultants' rights to private practice within the voluntary hospitals remained unchanged.
- 4.6 Thus within publicly-funded hospitals after 1953 there co-existed two distinct systems of consultant recruitment and remuneration. The level and operation of private practice in public hospitals received little explicit attention in official health policy statements of this period. The 1966 White Paper, for example, did not deal with the issue at all. However, in 1968 the Minister for Health set up a Consultative Council on the General Hospital Services, comprised of hospital consultants. Their report *Outline of the Future Hospital System* – known as the Fitzgerald Report – alongside its proposals for hospital reorganisation – recommended a unified consultant establishment. It envisaged salaried consultants being remunerated on a notional sessional basis and the continuation of private practice within the public hospitals (1968:89).
- 4.7 Some indication of the extent of private practice in this period and the official view on this issue can be found in responses to Parliamentary Questions. In 1972 the Minister for Health told the Dáil:

“I would however point out that about 16 per cent of the population are covered by the schemes of the Voluntary Health Insurance Board but that this group accounts for only 10.5 per cent of the bed-days in acute hospitals. This would seem to indicate that the demands by this group on hospital services are on the whole relatively light” (Dáil Éireann, Volume 264 12 December 1972).

Assuming that this statement referred to public hospitals and that average duration in hospital was the same for public and private patients, 10.5 per cent of bed-days would suggest an equivalent proportion of beds dedicated to private use. Public hospitals provided approximately 17,000 acute beds at this time.

11. The Minister for Health, at the behest of the Irish Medical Association, brought forward an amendment to this effect at Committee Stage.

Thus we can estimate that there were approximately 1,800 paybeds in the system at this time.

- 4.8 Following the recommendations of the Fitzgerald Report, the 1970 Health Act provided for the establishment in 1972 of a new body – Comhairle na nOspíéal, – to regulate the number and type of consultant appointments. The issue of a common consultant contract was mooted at various points through the 1970s. In 1977 the Government set up a Working Party on a Common Contract and a Common Selection Procedure for Consultants which issued an Interim Report in September 1978. Following this, new direct negotiations opened between the consultants representative organisation and the Department of Health and a ‘Common Contract for Consultant Medical Staff’ was agreed for the first time in 1981. This contract provided for a salaried consultant establishment in all public hospitals whether health board or voluntary, while allowing for private practice both within the public hospital and in the private hospital sector essentially on the model of the voluntary hospitals.
- 4.9 We saw above that in the early 1970s around 10 per cent of public hospital beds were supplied to private patients. Over the next decade the number of paybeds increased both in absolute terms and as a proportion of the total bed complement in public hospitals. In 1987, regardless of the increased share of private beds, the Minister for Health told the Dáil that:
- “The number of private and semi-private beds qualifying for Voluntary Health Insurance cover in the public hospital sector is relatively small at approximately 20 per cent. This number is tightly controlled by the Minister for Health and the VHI Board to cater as closely as possible for the known demand for such facilities”.*
- 4.10 Between 1979 and 1991 Category 3 patients were entitled to public accommodation but remained liable for specialist fees. (In addition, many people with Category 2 eligibility also had private insurance and paid for the consultant of their choice). Thus it was possible for someone to be a non-paying patient of the hospital in a public ward while being a private-paying patient of the consultant. At the time this caused particular problems for the control of private practice in the public hospitals, and this issue, rather than the overall extent of private beds, became the focus for policy initiatives.
- 4.11 Indeed, the Commission on Health Funding (1989) and the NESC recommended that the boundary between public and private beds be addressed in the context of the extension of eligibility for consultant services to the higher income group. This approach was adopted in the *Programme for Economic and Social Progress* (PESP) which stated that its objective was to ensure the greatest possible equity in the availability of health services, particularly in relation to equity of access to public hospital services and went on to commit the Government to merge the middle and upper income eligibility categories. In addition, the Programme stated that:

“There will be some modification of the present arrangements for admission to public ward accommodation in public hospitals. Under the new system, consultants private patients availing of public hospitals for elective (i.e. non-emergency treatment) will eventually be accommodated only in private or semi-private accommodation. This system will be phased in gradually during which period admission arrangements will be kept under review to ensure they operate in an equitable manner”.

- 4.12 The PESP further included an explicit commitment to otherwise maintaining the *status quo* in regard to private practice:

“The Government are committed to maintaining the position of private practice both within and outside the public hospital system. The Government also recognise the crucial role played by voluntary health insurance. In gradually implementing the new system the Government will be sensitive to the need to ensure that the public hospital system caters adequately for the requirements of private patients and that the important role and contribution of voluntary health insurance is not diminished in any way”.

- 4.13 The Health Services (In-Patient) Regulations 1991 put in place the bed designation system. This system was initially introduced on the basis of recognising existing arrangements. At the outset in 1991, 19.4 per cent of beds were designated as private, rising to 20.4 per cent in 1993 (see Table 4.1). This changed very little thereafter, accounting for 20.6 per cent beds in 1999. Non-designated beds – intensive care and other specialist beds – are open to both public and private patients. In practice, however, nearly 30 per cent of elective procedures carried out in public hospitals are on private patients.

Table 4.1 Bed Designation in Public Hospitals

Year	Public (%)	Private (%)	Non-Designated (%)	All (%)
1991	8,852 (73.1)	2,349 (19.4)	912 (7.5)	12,113 (100)
1993	9,016 (73.6)	2,500 (20.4)	739 (6.0)	12,255 (100)
1999	8,995 (73.2)	2,528 (20.6)	769 (6.3)	12,292 (100)

Source: Nolan and Wiley, 2000.

- 4.14 These arrangements for designating beds in public hospitals, as public or private, were negotiated in tandem with, and must be seen alongside, the issue of the treatment of private practice in the Common Contract. As already mentioned, the first Common Contract was agreed in 1981 and has since been renegotiated on two occasions – 1991 and 1997. The main changes concern the structure of consultant appointments. The original contract placed no specific

limits on individual private practice, either within the public hospital or in the private hospital sector. The latest Contracts establish two Categories of consultants, which differ in their provision for private practice in private hospitals.

- 4.15 Consultants holding Category 1 contracts can only treat patients (public or private) within their employing public hospital(s), although they can additionally see private patients in their private consulting rooms. Category 2 consultants may additionally treat private patients in private hospitals. As we have seen above, of 1,560 public hospital consultant posts at January 2001, 53 per cent were Category 1, and 37 per cent were Category 2.
- 4.16 All consultants' remuneration¹² is adjusted in order to take account of private practice within the public hospital. Basic payments are reduced by one of three rates – 10 per cent, 15 per cent or 20 per cent determined by a combination of speciality and location. The application of the abatement is not related to the extent of private practice at the level of individual consultants. The first Buckley Report on Hospital Consultants (Report No 32, 1990) took the view that abatement for private practice:

“should bear a more direct relationship to the relative numbers of public and private patients treated by each individual consultant. The principal justification for this is to establish a more equitable system both as between the employing authority and the consultant and, equally importantly as between different consultants. At the moment consultants with distinctly different levels of private practice have their public salaries abated by equal amounts: one consultant's percentage of private patients may be 40% and another's may be less than 5% but the salaries of both may be subject to a 20% abatement” (1990:Para 2.19).

- 4.17 The Buckley recommendations in this area were not taken up in subsequent re-negotiations of the Common Contract. However, the 1997 Contract includes a clause whereby an individual consultant's mix of public and private practice within the public hospital should conform to the breakdown of public-private beds under the bed designation arrangements.

Equity and the Public-Private Mix

- 4.18 While concerns about justice and fairness have probably always played a role in public debate on health policy, the concept of an equitable healthcare policy only came to prominence in Irish health policy debate in the 1980s. As elsewhere this was partly in response to the WHO's 'Health for All' initiative which raised particular concerns about social inequalities in health, and the position of specific disadvantaged groups. The equity implications of the public-private mix

12. Consultant salaries are calculated on a basic payment (the A factor) plus payments for on-call periods (B factor) and emergency call-outs (C Factor) – and a number of allowances.

in healthcare are a particular concern in Ireland. While such concerns were highlighted in *Health: the Wider Dimensions* published by the Department in 1986, and featured strongly in public and political debate¹³, the Commission on Health Funding provided the first in-depth consideration of the policy issues involved.

4.19 This Commission was set up in June 1987 and reported in September 1989. Its terms of reference were *“To examine the financing of the health services and to make recommendations on the extent and sources of the future funding required to provide an equitable, comprehensive and cost effective public health service, and on any changes in administration that seem desirable for that purpose”*. In essence, the Commission was asked to provide an overall review of the health services from the point of view of equity, comprehensiveness and cost-effectiveness and in this context it did not restrict its attention to public provision. Rather *“The term ‘public health services’ as contained in our terms of reference has a specific meaning in certain contexts. Throughout our report we interpret it as meaning **the total health and personal social services available to the public, including all services provided by public, private and voluntary agencies, irrespective of source of funding**”* (1989:1).

4.20 It is useful to distinguish the Commission’s general approach to equity in a health system which incorporates public and private care and its specific discussion of the provision of private care in public hospitals. The Commission elaborated the definition of equity as follows:

*“The concept of **equal access for equal need** is commonly used as a definition of equity. This does not have to imply the widespread geographical distribution of all services; efficiency criteria also determine the location of services, so that patients in certain areas may have to travel further than others for access to more specialised procedures. This concept does, however, imply that, **for those services which are considered necessary on the criterion of comprehensiveness, access of patients should be determined on the basis of their individual need for the service, rather than on, for example, their geographical location or their ability to pay.** The concept requires not alone that the necessary services are available to satisfy their entitlement, that these services are of high quality and are available within a reasonable period”* (ibid).

4.21 While the Commission (majority) supported a tax-financed universal public system, it specifically envisaged the continuation of both public and private care:

“The Commission believes that, in keeping with the political and social philosophy of our society, the individual should have access to self-funded medical treatment if he so desires. However we would regard it as inequitable if the provision of such treatment to those in a position to pay for it should act in any way to the

13. See, for example, the Dáil exchange on ‘Access to Hospital Services’ in February 1988.

disadvantage of those of lesser means by reducing the availability of resources such as skilled manpower. We believe that those in a financial position to obtain medical treatment which is generally unavailable should not be subsidised at public expense in doing so” (1989:66).

4.22 The Commission held that – assuming that people have fulfilled their obligations as citizens to pay their taxes – they should be free to spend their remaining income as they wish. It spelt out its view of the implications of this freedom for the relative access to healthcare of public and private patients as follows:

“It is inevitable that those able to obtain treatment in the private sector may be able to obtain certain treatment more quickly and that some treatments will be available only in the private sector, where the public sector has decided against offering them. It could only be otherwise if the public sector were to offer an unlimited range of treatment regardless of cost effectiveness. In summary therefore the Commission does not consider it inequitable that private insurance should enable individuals to obtain speedier or otherwise unavailable treatment, provided that comprehensive and cost effective publicly-funded health services are available within a reasonable period of time to all those assessed as in need of them” (1989:13).

4.23 Thus, it saw the central requirement of equity in this general sense as developing a comprehensive public service that ensures timely access for necessary treatment. The Commission was not specific about the definition of ‘a reasonable period of time’. However the Commission explicitly stated: “A fundamental principle of the majority of the Commission is that it should not be necessary, nor should it be perceived as such, to take out private insurance in order to secure access to necessary treatment” (1989: 13). This seems to imply little significant difference in waiting times for public and private patients for essential services. Indeed, they went on to argue that there should be no difference in the treatment of public and private patients within public hospitals.

Equity of Access to Public Hospitals

4.24 Equity of access to public hospitals was identified as a specific concern by the Commission. An important factor here was the stipulation in the original Common Contract that in public hospitals medical need should be the overall criterion for access to hospital and that admissions should be arranged accordingly. The Commission envisaged the continuation of the system of allowing private practice in public hospitals, and supported clearer demarcation/ boundary setting between public and private beds, but argued that the potential for unequal access inherent in these arrangements should be directly addressed:

“It is inequitable that patients in medically similar circumstances do not have equal access to services. As a result, unnecessary frustration and suffering is

caused to those on long waiting lists. To overcome this problem, we recommend the introduction of an objective system of assessment for access to publicly funded hospital services. This would relate to all planned admissions, whether to public or private accommodation, and would result in a common waiting list from which cases would be taken in order of medically established priority rather than the type of accommodation sought” (1989:239).

- 4.25 Note that the proposal is not simply for unified lists. The core idea is that access to public hospitals be based on objective assessment or prioritisation on the basis of medical need. Applied to both public and private patients this would by definition produce a common waiting list. There is a clear parallel here with the Australian experience outlined above. Subsequently, the National Economic and Social Council in referring to the Commission’s approach stated that: *“The Council would regard as fundamentally at variance with the principle of equity a situation in which persons availing of private care would have earlier or easier access to necessary hospital services than public patients” (NESC 1990: 290)* and it raised some concerns about the feasibility of the common waiting list proposal:

“Under the regime proposed by the Commission a common waiting list would be used to filter access to hospital beds – consultants however would be involved in the compilation and administration of such a list. Can this ‘list’ then be an effective instrument, if consultants have an incentive (on their private patients fee for item of service insurance) to admit private and not public patients? Further, to what extent can medical need and medical priority be objectively decided” (NESC 1990:290).

- 4.26 The Commission wanted its proposed system to be introduced as soon as possible and no later than the abolition of Category 3 (1989:379). However, the common waiting list recommendation was not adopted at that time or subsequently (as mentioned above, legislation was passed instead requiring the designation of beds as either public or private and prohibiting the use of beds designated as public by private elective patients), while the 1991 renegotiation between the Department and the consultants of the Common Contract dropped the stipulation that admissions to public hospitals should be according to medical need.

Development of Policy on Equity of Access

- 4.27 In 1994 the Department of Health published *Shaping a Healthier Future* (DOH, 1994). In this Strategy Document equity was named as one of three key principles underpinning the Strategy. (The others being quality of service and accountability). *Shaping a Healthier Future* elaborated on the principle of equity as follows:

“The achievement of an equitable health service has a number of dimensions. Access

to healthcare should be determined by actual need for services rather than ability to pay or geographic location. Formal entitlement to services is not enough; those needing services must have them available within a reasonable period. Furthermore, the pursuit of equity must extend beyond the question of access to treatment and care and must examine variations in the health status of different groups in society and how these might be addressed. ... The Strategy contains important steps to ensure greater equity in: implementing uniform rules for eligibility and charges for services across the country; measures to reduce waiting times for those availing of public services; giving special attention to certain disadvantaged groups” (1994:10).

- 4.28 The view of equity of access here is clearly based on the general discussion of the Commission on Health Funding outlined above. From the point of view of practical policy, equity of access was to be addressed by action on waiting lists/waiting times, especially through the Waiting List Initiative established in 1993. However, policy in this area has focused, in the main, on addressing the very longest waiting lists. We examine this issue further in Sections V and VI.
- 4.29 The implications of the public-private-mix for equity were also addressed in the 1999 White Paper on Private Health Insurance. Box 1 below outlines the advantages and drawbacks identified in that White Paper regarding the public-private mix in the hospital system.

Box 1	
ADVANTAGES AND DRAWBACKS OF THE PUBLIC/PRIVATE MIX IN THE HOSPITAL SYSTEM	
<p>Advantages</p> <ul style="list-style-type: none"> ● helps to attract and retain consultants of the highest calibre in the public system; ● promotes more efficient use of consultants time by having public and private patients on the same site; ● facilitates active linkages between the two systems in terms of research and best practice; ● enables patients to avail of private health-care when admitted to public hospitals on an emergency basis; and ● represents an additional income stream to the public hospital system. 	<p>Drawbacks</p> <ul style="list-style-type: none"> ● absence of economic charging for use of public hospital pay-beds; ● incentive for consultant to spend more time with private patients; ● perception that public patients tend to receive more of their care from medical staff other than consultants; and ● growth in coverage of private health insurance a potential threat regarding access for public patients.

Source: White Paper on Private Health Insurance, 1999, p13.

- 4.30 In addition to further discussion of policy to reduce waiting and to improve the public system, the White Paper – although having agreed in favour of continuing the mix in public hospitals – highlighted a number of factors that may lead to inequities in the distribution of public facilities between public and private patients: *“A more rigorous enforcement of hospital management of the bed designation arrangements currently in place and of the terms of the 1997 Consultants Common Contract governing the extent of private practice by individual doctors can also support equity in relation to public patient access”* (1999:18).
- 4.31 Apart from these important management issues, the White Paper also highlighted the absence of economic charging for the use of hospital beds as a significant policy issue. Essentially, under current arrangements, charges for private patients in public hospitals are not explicitly related to the cost of the services provided and are significantly lower (estimated to be only half the real cost) than those charged in the private sector. The White Paper stated that the Government would review charging arrangement to tie them more closely to costs. This was to be implemented over a 5-7 year period from 1999. While this has not been fully implemented, it should be noted that there have been successive annual increases in charges, including a 15 per cent increase with effect from 1st January last.

Conclusions

- 4.32 This Section has focused on the way the public-private mix in Irish hospital care, and views about what is equitable in this context, have evolved. It first brought out the long-standing commitment in public policy to maintaining private practice, both within and outside the public hospital system. It then highlighted how concerns about the equity aspects of the public-private mix first came to the fore in the 1980s, and were addressed by the Commission on Health Funding. This Commission, importantly, argued that access of patients to necessary healthcare should be determined on the basis of their individual need for the service, and that equity also requires that these services are available to everyone at a high quality and within a reasonable period.
- 4.33 The Commission regarded it as inequitable that patients in medically similar circumstances do not have equal access to public hospitals and recommended that a common waiting list for all patients be established. This was not adopted, although essentially the same definition of equity was spelt out in *Shaping a Healthier Future* in 1994. Instead, from the early 1990s the focus of policy has been on clarifying the boundary between public and private care in public hospitals and on increasing the charges levied for occupying private beds. In that situation access to public hospitals, and waiting lists in particular, have come to be a central focus of policy and public attention, and this is discussed in the next Section.

Section V

Waiting for Public Care

Section V:

Waiting for Public Care

Introduction

- 5.1 Adequate access to public hospital care is widely regarded as a central element in a satisfactory public health system, and where this is perceived not to exist the result is widespread concern. This is exacerbated when access is perceived to be not only inadequate but also unfairly allocated, as between for example public and private patients or geographical areas.
- 5.2 In Ireland – as in some other countries – waiting lists for certain types of public hospital care have come to be seen as a key indicator in the performance of the system and a central focus of policy and public attention. This Section begins by describing the pathway to hospital care in this country and the various points where patients may wait for treatment. It then looks at recent waiting list data, drawing on the Department of Health and Children’s national database. The type of information collected and related issues are discussed and trends in the data examined. Finally, we briefly discuss some international comparisons.

Pathways to Hospital Care

- 5.3 General Practitioners (GPs) are in most cases the first point of contact with the health services. Approximately 2,300 GPs in Ireland carry out an estimated 16.2 million GP consultations per annum (Boland, 1998 and Murphy, 1998). In common with a number of other countries, GPs act as gatekeepers to specialist medical services. The vast majority of GP consultations do not result in referral to a specialist. Boland notes: “*An average GP will manage 96% of his/her consultations so that fewer than 4% of consultations result in a referral to a specialist*” (1988:48). Such a referral rate is low by European standards (Maguire, 2000).
- 5.4 GPs make both immediate referrals to hospitals and referrals to consultants’ outpatient clinics. According to Conlon *et al* “*The system of access to acute hospital beds for General Practitioners (GPs) in Ireland differs between health boards, between hospitals within health boards and between specialities within hospitals*” (Conlon *et al* 1998:). GP referrals for emergency admission join emergency admissions arising from other sources – e.g. accidents, other emergencies, and referrals by consultants. About 30 per cent of hospital admissions are arranged through Accident and Emergency (A&E) Departments and only a third of these originate with a GP (Boland, 1998:45). In all, approximately two-thirds of overnight

admissions to acute general hospitals are emergency and this, in turn, frequently interferes with schedules for elective admissions.

- 5.5 Apart from immediate referrals, GPs refer patients requiring specialist assessment or treatment to consultants. Consultant appointments may be on a public (no-fee paying) or private (fee-paying) basis. No national data is collected on those waiting for a first consultant appointment, although experience elsewhere suggests that this stage may account for a significant part of the total waiting experienced by patients. This issue has been addressed in a number of local Irish studies. For example O’Connell *et al* (2000), in a study of 100 patients undergoing total hip replacement in one unit, reported a median wait of 3.5 months for an initial appointment. This was higher than an earlier study of 24 orthopaedic patients which found a median wait of 2.75 months (Maguire, 2000). These studies do not distinguish between public and private consultations. However, it is generally accepted that it takes considerably longer to obtain a public consultation.
- 5.6 Arising from an initial assessment, consultants may list patients for admission to hospital as either public (no-fee paying) or private (fee-paying) patients. As we have seen within the publicly-funded hospital system, in-patient and daybeds are designated, in most cases, as either public (for the use of non-fee paying patients) or private (for fee-paying) patients. For both public and private patients, elective admission is determined by bed availability. In practice, the level and characteristics of the demand for private beds means that private elective patients rarely face significant delays. This is not the case for public patients.

Irish Waiting List Data

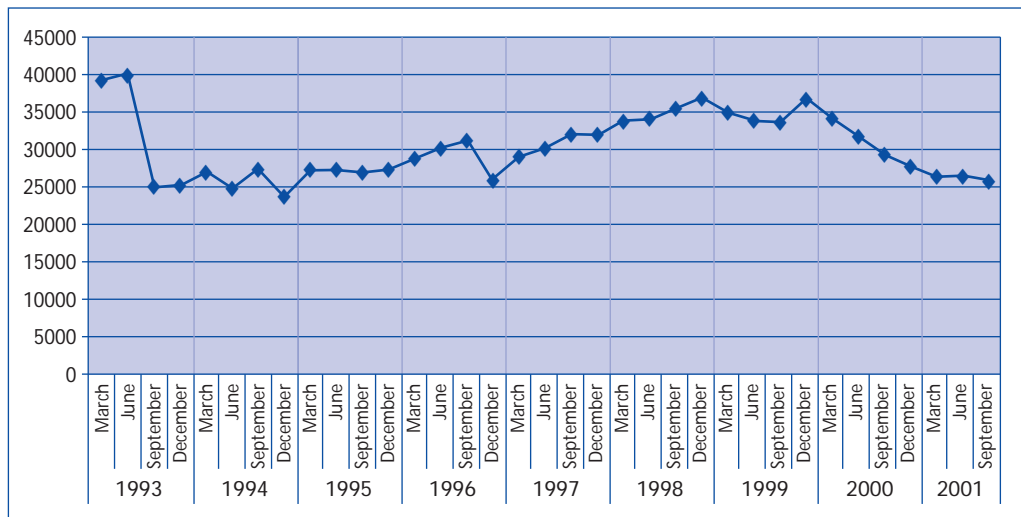
- 5.7 Since the inception of the National Waiting List Initiative (WLI) in June 1993, the Department of Health and Children has maintained a national database of information on waiting lists. This data are compiled from quarterly returns from hospitals and are primarily collected for the purpose of administering Waiting List Initiative funding.
- 5.8 National totals for end-March, June, September and December are issued by Departmental Press Releases. There is no standard waiting list bulletin or release, as is the case in Northern Ireland for example. However, breakdowns of the data (by specialty, hospital, Health Board, etc.) are available from the Department. The latest (September 2001) figures were released on 19 December 2001.
- 5.9 Before describing the data, it is important to clarify what the published totals represent. They are based on partial data on those who, having seen a

consultant, have been listed for public overnight or same day treatment. The WLI return form does request separate totals on public and private in-patient waiting lists by speciality. However, not all hospitals return data on private lists and the data that are collected are not all collated by the Department. In addition, the returns to the Department only include data on those public patients who have already been waiting for three months or more. Thus, the available national waiting list data do not include all those actually on waiting lists or even all those on public lists. This should be kept in mind throughout the following discussion.

- 5.10 A number of other general points about the data should be made. First, we need to be clear about the nature of the measure used. Broadly speaking, measures of waiting lists or times are of two types. Census-type measures count the numbers waiting at a particular point in time and the time they have waited to that date. Throughput measures report the extent of waiting (e.g. since specialist referral) experienced by all those admitted for treatment in any given period and thus are a more complete measure of waiting time. The Irish data described here is based on a census-type measure.
- 5.11 Second, there is an issue concerning the reliability of the data. Experience both here and abroad suggests that many people included on waiting lists are in fact not still waiting for medical care. This can arise for a number of reasons, including an individual being included on more than one list, having been treated elsewhere in the meantime e.g. privately, a change in their medical condition, or where people on a waiting list emigrate or die. Recently, the issue of waiting list validation has been highlighted in the context of assessing the factors behind improvements in waiting list totals. However, while concerns about ‘massaging’ statistics are important, so too are ensuring the accuracy of the data and underpinning service efficiency (e.g. by reducing cancellations and non-attendees).
- 5.12 Figure 5.1 below presents quarterly waiting list totals from 1993 to date. It will be noted that the totals fell very sharply in mid-1993. This followed the introduction of the Waiting List Initiative and *“Part of this reduction arose from a validation exercise which removed those not actually awaiting treatment”* (Review Group, 1998:4). While quarterly totals moved erratically between September 1993 and September 1995, the underlying trend was slowly upward in this period. From September 1995 to December 1998, waiting lists increased more sharply. The total increased in every quarter from end-1995 to end-1998 with the notable exception of end-1996 when there was a significant fall. There has been only one significant increase over the last three years and that was in December 1999. (The nurses’ strike that occurred in this period was probably a factor here). The numbers fell by almost a quarter between December 1999 and December 2000, but have levelled off considerably since then. List validation (arising from factors

such as whether the patient received treatment elsewhere through, for example, the private health sector, or gone abroad, or died) has played some part in the recent reduction in waiting lists but how much is unclear.

Fig. 5.1: Waiting Lists, March 1993 - September 2001 (Quarterly Totals)



Source: Department of Health and Children.

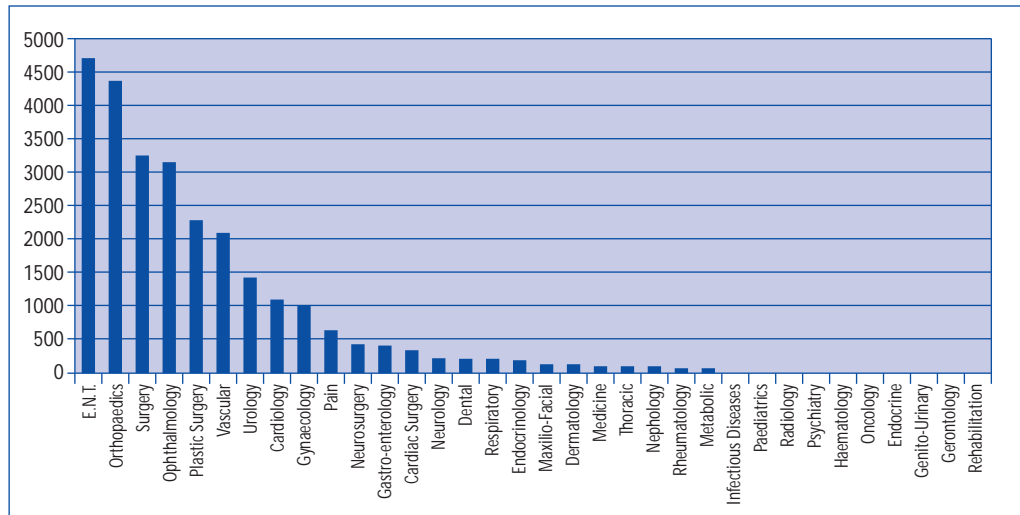
5.13 To put the situation in context, waiting list data are sometimes expressed in relation to hospital throughput. For example, in his address to the Forum’s Plenary Session on 2nd October last, the Minister for Health and Children mentioned that “*against the background of overall hospital activity of 870,000 in-patient discharges in 2000, the number of people on hospital in-patient waiting lists represents only 3 per cent of all discharges*”. We noted earlier that the waiting list data, which provides the numerator of this ratio, do not include all those on waiting lists or even all those on public in-patient lists. On the other hand, the denominator used, i.e. the figure of 870,000 for public hospital activity in 2000 includes both public and private in-patient and day case activity.

5.14 Figure 5.2 presents the most recent breakdown of the waiting list by speciality. It will be seen that waiting list size varies substantially across specialties. Three specialties – Ear, Nose and Throat (ENT), Orthopaedics and Ophthalmology – together account for almost half (46.6 per cent) of all those waiting. Ten specialties account for the majority (89.8 per cent) of the waiting list. Nine of these – cardiology is the exception – are surgical specialties. These nine are the ‘Target Specialities’ under the Waiting List Initiative.

5.15 Particular concern is often expressed about long waits for cardiac surgery. There were 299 people waiting in this speciality at September 2001, down 60 per cent since September 2000. Cardiac Surgery now accounts for just over 1 per cent of the total waiting list. A further 1,078 (4.1 per cent) were cardiology patients. As

we show below, Cardiac Surgery is the target speciality that has seen the most consistent decline in waiting lists and waiting times in recent years.

Fig. 5.2: Waiting Lists by Specialty, September 2001



Source: Department of Health and Children.

- 5.16 Data on waiting list trends in the main specialties are available since 1996. Details are presented in Annex I, Table 5.1, but the key features of the pattern shown are summarised here. Waiting lists overall were 7 per cent higher in 2000 than in 1996, and were even higher again in the intervening years. The rates of increase and decrease over the period differed across specialties, although in many instances the same specialties recorded both the largest increases and the largest subsequent falls.
- 5.17 More specifically, and comparing end-2000 to end-1996, waiting lists for General Surgery and ENT increased moderately while lists for Orthopaedics, Urology, and Vascular Surgery fell moderately. The waiting list for Cardiac Surgery in 2000 was almost two-thirds lower than in 1996 while Gynaecology fell by more than a quarter. Cardiology and Ophthalmology increased more significantly, by one-fifth and by more than one-third respectively. The largest rate of increase was for Plastic Surgery, which increased in all years except 2000 and was 119 per cent higher in 2000 compared to 1996. There was also a very large increase in 'other specialities', which was 83 per cent higher in 2000.
- 5.18 Since December 2000, the overall waiting list has been reduced from 27,857 to 26,659 in end-September 2001 – an overall reduction of 4 per cent. The Cardiac Surgery list has been reduced by 45 per cent and the ENT list by about 13 per cent, for example. The waiting list for Surgery, however, has increased by 20 per cent and the Cardiology list has increased 14 per cent.

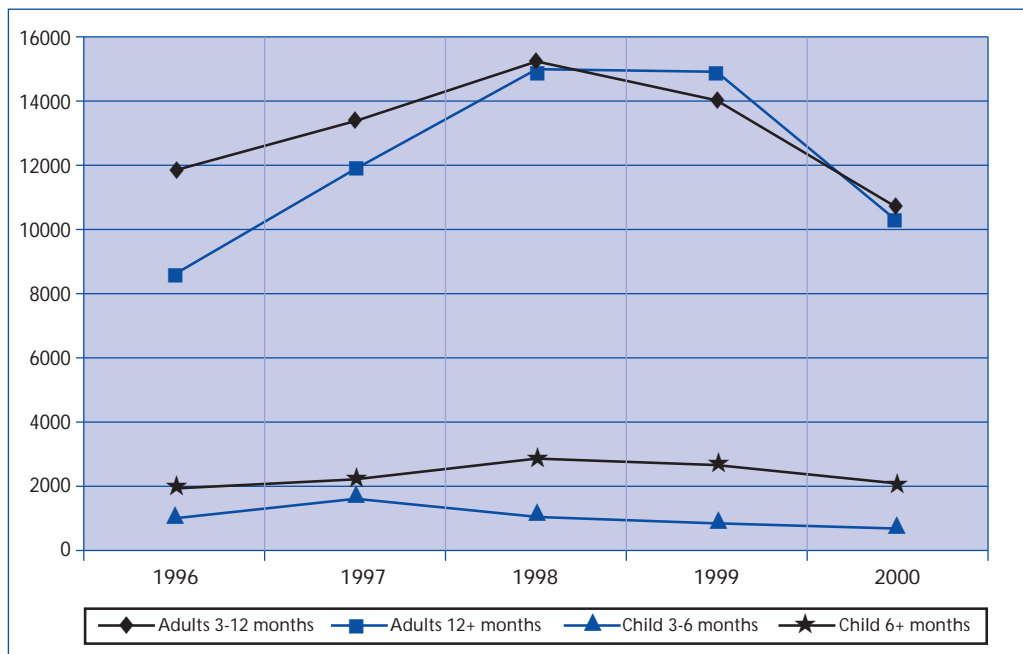
Adults and Children

5.19 For the nine ‘Target Specialities’ included under the Waiting List Initiative, more detailed data are available distinguishing between adults and children in the patient population, and within these by longer durations (over twelve months for adults and over six months for children).

5.20 At December 2000, there were 24,014 on waiting lists for these specialties, or 86 per cent of the total waiting. Of these, 88 per cent were adults and 12 per cent were children. Among the children, 74 per cent¹⁴ had been waiting for more than 6 months while the adults were evenly divided between those waiting 3-12 months (51 per cent) and those waiting more than a year (49 per cent). Among adults, Figure 5.3 shows that the most notable trend since 1996 is that as the list increased, long-waiters increased more rapidly, while as the list declined the rate of decline was similar at both durations. As a result, the proportion of long-waiters increased from 42 per cent in 1996 to 49 per cent in 2000 (Annex 1, Table 5.2). The share of long-waiters among children has also increased from 65 per cent in 1996 to 74 per cent in 2000. However, by end -September 2001, this had fallen to 69 per cent.

5.21 The most recent data (end-September 2001) shows a continuing decline in the waiting list to 22,587. The exception to this trend is for children waiting 3-6 months, which increased by 21.7 per cent over the nine-month period (December 2000 to end-September 2001).

Fig. 5.3: adults and Children by Duration, 1996 - 2000



Source: Department of Health and Children.

14. This contrasts with VHI research showing that nearly 80% of its members are hospitalised within 2/5 weeks of seeking an admission.

Long-Waiters

- 5.22 We now focus on long-waiters in the target specialties, i.e. adults waiting more than 12 months and children waiting more than 6 months. Annex 1, Table 5.3, presents trends among adult long-waiters by speciality, showing end-year totals and a waiting list index. The total increased between 1996 and 1999, with very sharp increases in 1997 and 1998. In 2000, there was a very sharp fall in the overall total. Nevertheless, the number of adult long-waiters was 26 per cent higher in 2000 than in 1996. Comparing end-2000 to end-1996, there were fewer long-waiters in only two specialties: Cardiac Surgery where there was a dramatic decline, and Orthopaedics where there was a modest one. Exceptionally large increases occurred in ENT and Plastic Surgery.
- 5.23 Over the nine-month period December 2000 – September 2001, the number of adults waiting over 12 months for these specialties fell by 9 per cent overall. Above average reductions were evident in ENT, Gynaecology and Orthopaedics, and Cardiac Surgery again showed the most dramatic reduction – down 63 per cent in nine months. Increased waiting lists were seen in General Surgery and Ophthalmology.
- 5.24 It is also useful to look at trends in long-waiters by speciality expressed as a percentage of the specialty total. This is detailed in Annex I, Table 5.4. While these data are frequently reported as the proportion of those on waiting lists for over a year, this is not strictly correct as the exclusion of those waiting less than three months from the totals has the effect of inflating the percentage of cases reported as exceeding the duration thresholds.
- 5.25 Presenting the data in this way raises two additional aspects of interest, however. Firstly, there is a variation in the prevalence of long-waiters across speciality. The proportion waiting over 12 months at end-2000 varied from 68 per cent in Plastic Surgery down to 27 per cent in Ophthalmology, with percentages in the other specialties widely distributed in between. In addition, this variation seems to have been quite stable over the recent period. It is worth noting also that there seems to be no direct relation between list size and the proportion of long-waiters on the list.
- 5.26 Secondly, within specialties, any change in this proportion indicates a divergence in the performance of the long duration and shorter durations segments of the waiting list. In other words, an increase in the proportion indicates that long-waiters have increased more rapidly or fallen more slowly than those waiting 3-12 months and *vice versa*. We saw earlier, for example, that waiting lists in all specialties declined in the last year. In General Surgery, Vascular Surgery and Gynaecology the numbers waiting from 3-12 months and those waiting for more than a year declined at much the same rate. In Plastic Surgery, Urology and to a lesser extent ENT, the rate of decline was slower

among those waiting over one year, while it was faster among this group in Cardiac Surgery, Orthopaedics and Ophthalmology.

5.27 Focusing on children waiting more than 6 months, at end-December 2000 ENT alone accounted for 58 per cent of children on waiting lists in the Target Specialties and 63 per cent of long-waiters (see Annex 1, Tables 5.5 and 5.6). Plastic Surgery accounted for a further 18 per cent of all children and 20 per cent of long-waiters. Thus, in many specialties the numbers involved are very small and not too much can be made of the trend data. While the waiting list for ENT has fallen in recent years, the proportion of long-waiters has increased to 80 per cent. Finally, there has been a marked increase in the number of children waiting for Plastic Surgery. Initially the rate of increase was faster among those waiting 3-6 months, but longer-waiters have grown faster in recent years and now comprise 84 per cent of the total list.

5.28 In the nine-month period end-December 2000 to end-September 2001, the number of children waiting more than six months has decreased overall by about 5 per cent, but there is considerable variation by specialist. In the case of ENT, Ophthalmology and Orthopaedics, the numbers waiting for longer periods has reduced by about one-quarter respectively. In contrast, the number waiting for Plastic Surgery has increased slightly, but there has been a very marked increase in the number of children recorded waiting for six months or more for Surgery.

Comparative Data on Waiting Lists

5.29 It would be useful to have meaningful comparisons between waiting lists or waiting times in Ireland and in other countries. However, making such comparisons is very difficult. A recent report on this issue from the Oireachtas Joint Committee on Health and Children noted that:

“We experienced significant difficulty in drawing a comparative picture of waiting lists across Europe because of the lack of available information. According to the office of the European Commission in Luxembourg, comparative data on waiting lists simply does not exist” (JCHC 2001:6).

5.30 It is, therefore, worth noting the following announcement of an OECD project on this issue:

“Excessive waiting times for non-emergency surgery are a major source of public dissatisfaction and hence a major health policy problem in many OECD countries. It is planned to carry out a project to investigate and compare across selected OECD countries: i. measures Member countries have taken to tackle excessive waiting times; and ii. the causes of variations in such waiting times.

Initially, it is planned to assemble existing data, where it is available, on waiting times and surgery rates across countries. At a later stage, consideration will be given to collecting additional data, specifically for the project. The project is planned to start in 2001 and last for two years” (OECD 2001).

- 5.31 While comparative data are not produced by any international organisation, data on waiting lists and/or waiting times are reported at national or regional level in a number of other countries. However, even where such data are available, definitional and other methodological differences (not least the restriction of the Irish data to those waiting over three months, discussed earlier) make direct comparisons difficult.
- 5.32 Nevertheless, some general points of comparison are worth making. Firstly, waiting lists – though **not** necessarily long waiting times – are arguably ‘normal’ features of certain types of healthcare system and not of others. It has been suggested that *“lists occur where there is a combination of tax finance and global budgets. Countries in which lists are used include the UK, the Nordic countries, Canada, Australia and New Zealand”* (Cullis *et al*, 2000:1203). France and Germany, on the other hand, are examples of systems where waiting lists typically do not occur, as their systems are largely demand-led.
- 5.33 Secondly, it is worth noting that experience in a number of other ‘waiting list’ countries seems to suggest that significant progress can be made in reducing lists, and especially in addressing very long waiting times. Norway and New Zealand, for example, are countries of similar population to Ireland (although much larger in territory) and both have universal public health services. Regarding Norway, van den Noord *et al*, (1998) report that waiting lists rose from 227,000 to 331,000 between 1993 and 1996, with those waiting over six months increasing from 3,000 to 19,500 with the result that *“waiting times have become a major issue in the health policy debate in Norway and are widely seen as unacceptable by the public”* (1998:19). This suggests a problem of long waiting in 1996 of a similar order of magnitude as in Ireland. However, the situation seems to have improved since then. A later report on health care in Norway (HiT2000) found that since the summer of 1997 the number of patients waiting at any time has been fairly constant at around 280,000, while the number waiting over three months has fallen significantly (almost to zero in target specialties) as a result of an improved waiting list initiative. New Zealand presents a further interesting comparison. Official figures from there show that the number of patients waiting more than six months for elective treatment fell from 44,999 in December 1998 to 15,188 in September 2000.
- 5.34 According to a recent report in the British Medical Journal, Spain is another country that has achieved a very significant reduction in long waiting times within its National Health Service. Within the INSALUD, which covers around

half the Spanish population, waiting lists for surgical procedures were reduced by an average of 20 per cent between July 1996 and March 2000. The number of patients waiting more than six months for an operation decreased by 96 per cent during this period (Bosch, 2000, 320:1559; see also HOPE, 2001). This was attributed to targeted waiting list initiatives.

Conclusions

- 5.35 Much of the concern being expressed about the public healthcare system in this country focuses on access to public hospitals, and on the length of time people have to wait before they receive certain types of care. This Section of the Report has explored the nature of the data available on waiting lists in Ireland, examined key recent trends over time, and brought out the limitations of the information as an indicator of time spent waiting for care.
- 5.36 General trends in the Irish data show some recent reductions in waiting lists, though this is not the case in all specialities and an age or gender analysis of the data is not currently possible. Waiting – insofar as it is reflected in official data – is concentrated in certain specialties, but the data are seriously inadequate. Improved recording should focus on waiting times rather than the stock of people waiting, and should incorporate time spent waiting to see a specialist as well as time spent from referral by a specialist to then receiving hospital care. While some other countries do indeed have similar waiting lists, examples can be found of substantial reductions achieved in these lists over a relatively short period of time.

Section VI

Policy on Waiting for Hospital Care

Section VI: Policy on Waiting for Hospital Care

Introduction

- 6.1 The previous Section brought out the central focus that waiting lists have assumed in debates about equity of access to public hospitals in Ireland, and the way waiting lists have evolved over recent years.
- 6.2 This Section now focuses on the approach taken by policy-makers to waiting lists. It discusses first some general issues in this regard, and then looks at the variety of Waiting List Initiatives implemented in recent years to try to reduce the numbers on these lists. The implications of shifting from a focus on waiting lists to waiting times are then discussed, together with the importance of being able to prioritise patients for admission and treatment.

Understanding Waiting Lists

- 6.3 Waiting lists by definition arise because of a mismatch between supply of and demand for treatment. However, in order to understand waiting list developments, it is important to clarify the nature of the mismatch involved. A number of issues are important here. First, it is necessary to think in terms of flows rather than stocks. Existing data on waiting list represent the stock of people waiting for treatment at any given time. However, the level of this stock depends on the inflows and outflows into the waiting list over time. In any period where the current supply of procedures falls short of (exceeds) current demand then the waiting list grows (falls). Thinking in this way about waiting lists suggests an important analytical distinction between the backlog of unmet demand from earlier periods and a shortfall of current supply relative to current needs. The following simple Table can illustrate this.

Table 6.1: Illustrative Waiting List Flows

Period	Referrals	Procedures	Waiting List
1	1000	1000	0
2	1000	1000	0
3	1100	1100	0
4	1200	1100	100
5	1300	1200	200
6	1300	1300	200
7	1300	1300	200
8	1300	1400	100
9	1300	1400	0
10	1300	?	?

Source: Forum Secretariat.

- 6.4 In Year 1, 1000 people are referred for treatment. The same number are treated and there is, therefore, no waiting list. The same thing happens in Year 2 while in Year 3 both the number of people referred and the number treated increases to 1100. Once supply of treatment equals demand, (i.e. new inflows equal outflows), no one is added to a waiting list. However, if referrals increase again to 1200 in Year 4 while the numbers treated remains unchanged at 1100, demand exceeds supply and for the first time we have 100 people on a waiting list. In Year 5 both referrals and treatments increase by 100, but current inflows again exceed current outflows and another hundred people join the waiting list which increases to 200. In Years 6 and 7 the number of procedures again matches the number of referrals and the waiting list remains unchanged. In Years 8 and 9 the number of procedures exceeds referrals, in each case by 100 and the waiting list is reduced and then eliminated. Finally, in Year 10, if referrals remain unchanged, then the number of procedures is limited to this amount i.e. limited by demand rather than supply and there is unused (wasted) capacity.
- 6.5 Within this framework, waiting lists should be addressed by a combination of:
- (a) planning the underlying capacity of the system with the objective of matching current demand and supply; this avoids the creation of waiting lists, or stabilises existing lists by matching inflows and outflows; and
 - (b) mobilising additional – possibly temporary – capacity to eliminate the waiting list backlog or at least to reduce it to an acceptable level.
- 6.6 Obviously these raise issues of a very different order. In the first case, the focus is not on waiting lists *per se*. Rather waiting lists are a symptom pointing to

difficulties elsewhere. Addressing the underlying capacity of the system with the objective of matching current demand and supply in any year involves potentially all aspects of health service planning and delivery. At the broadest level, as recent debates in Ireland have shown, it involves issues concerning the level of healthcare investment and the nature and structure of healthcare financing. Below this very broad level, a wide range of service planning issues are important. For example the Review Group on the Waiting List Initiative (1998), alongside its recommendations on the design and implementation of the Initiative, recommended measures to improve bed management, utilisation and discharge planning, a continued move to day case work, measures to reduce the pressure on acute beds from A& E services, and targeted review and development of hospital capacity. These were largely addressed to the hospital sector (and to lesser extent to the interface between primary and secondary care).

- 6.7 In addition, the Review Group specifically argued that *“a satisfactory response must reach beyond the acute hospital services alone”*. It therefore also made a series of longer-term recommendations concerned with wider issues of service planning, especially the issues of ‘inappropriate’ use of acute hospital beds. It suggested that approximately 418 (3.5 per cent) acute hospital beds were inappropriately occupied at any given time (DOHC 1998:22). The Group argued that:

“shortfalls in the provision of services for older people (and others who may need long-term care) such as day investigation facilities, rehabilitation facilities, community-based support services and long-term residential care places... result in inappropriate use of acute hospital facilities and thus severely hamper the ability of hospitals to provide treatments to patients on public waiting lists” (DOHC 1988: ii).

It went on, therefore, to make recommendations on a strategy for long-term care and for the development of Geriatric Day Hospitals and rehabilitation facilities.

- 6.8 Policies to address waiting lists in key specialities such as cancer or cardiac surgery have had elements of an integrated planning approach. However, policy measures that are specifically focused on waiting lists *per se* are typically concerned with mobilising additional – usually temporary – supply as a means of addressing accumulated backlogs on waiting lists. This ‘backlog’ view of waiting lists informs policies like our Waiting List Initiative and similar initiatives elsewhere.
- 6.9 The Irish Waiting List Initiative (WLI) has been in place since 1993 and has been funded to a total of €202 million up to end-2001. The aim of the WLI is to reduce waiting times for in-patient procedures in public hospitals to no longer than 12 months for adults and 6 months for children. The Initiative is operated on the basis of dedicated funding from the Department of Health and Children to

health agencies to enable hospitals to carry out additional elective procedures over and above the activity that would have been performed in the hospital from normal funding. Table 6.2 shows the amount of funding provided under the WLI from 1993 to 2001.

Table 6.2 Waiting List Initiative Expenditure, 1993 - 2001, €m

Year	Amount (€m)
1993	25.40
1994	12.70
1995	10.16
1996	15.24
1997	10.16
1998	15.24
1999	25.39
2000	43.90
2001	43.81
TOTAL	202.00

Source: Department of Health and Children.

- 6.10 Each Health Board and the Authority employ a waiting list co-ordinator who liaises with the hospitals within their areas and with the Department. Guidelines, prepared by the Department, are issued annually to the Waiting List Co-ordinators. These guidelines outline the arrangements for the return of waiting lists / waiting times information and give revised guidance on the development and implementation of service plans for elective procedures and waiting list / waiting times. The most recent set of guidelines to issue was in February 2000.
- 6.11 The amount of funding available to each Board/Authority/Voluntary Hospital is indicated in the Letter of Determination each year. The detailed application of the funding is set out in the Board/Authority/Voluntary Hospital services plan. Following on a recommendation in the Report of the Review Group on the Waiting List Initiative (1998), a proportion of the WLI funding was retained by the Department in 2000 and 2001 for distribution to those agencies which showed the greatest ability to reduce their waiting lists and had further capacity available to use the additional resources.
- 6.12 The Health Boards and the Eastern Regional Health Authority collect and collate waiting list figures from their hospitals. These figures are then supplied in the format set out by the Department on a quarterly basis (see Section V above). From the figures supplied, the Department monitors and evaluates the

performance of the respective agencies. However, due to limited resources and the type of information supplied by the health agencies, it is not possible to carry out any in-depth analysis of activity in a particular hospital or Health Board.

- 6.13 WLI funding is allocated to the agencies by the Department of Health and Children. Once this has been received, it is then the responsibility of the relevant health agencies to manage this funding and to identify the surgical areas where it can be used most effectively. Health agencies have commissioned waiting list procedures in their own hospitals and from private hospitals. Waiting list procedures are also commissioned from Northern Ireland and the Eastern Regional Health Authority undertake some children's cardiac surgery in the United States.
- 6.14 A recent study gives some indication of how the WLI operates at hospital level. Funding is made available in the form of incentives to carry out additional activity drawn from the waiting list: *"At hospital level incentives were offered to those complying with each initiative as follows: purchase of endoscopic and ultrasound equipment; incentive payments to hospitals by re-imburement of day case costs; renovation and refurbishment of wards and departments; minor increases in part time and full time staffing levels"* (HOPE, 2001) and *"The funding which was provided for the waiting list initiative provided hospital managers for the first time with a negotiating tool with which to meet hospital consultants. Given the system of reporting relationships which pertain, hospital managers felt that it would have been difficult if not impossible to ensure the compliance of consultants without such funding"* (HOPE, 2001).
- 6.15 While the rationale for targeted waiting list funds seems clear – essentially in terms of addressing backlogs – it must be acknowledged that there are conflicting views as to their value, particularly over the long-term. A recent Canadian review, for example, argues: *"Various policies have been adopted to address waits for care. Based on the limited information available, it is evident that increased resources alone have not resolved the problem of waiting lists. Policies based on increased and targeted funding adopted both abroad and in Canada have often been unable to produce a long-term sustained reduction in waits"* (WCWL, 2001:4). A number of issues should be distinguished in the assessment of waiting list initiatives. Firstly, measures to reduce waiting lists backlogs may be offset by new inflows where underlying supply and demand are not matched. This may make their effect hard to detect but it does not necessarily mean that there is no effect. Secondly, even if the rationale for Waiting List Initiatives is accepted, the impact of any particular policy of this type will depend on its specific design and implementation.
- 6.16 In a summary of key service developments, the new Health Strategy *Quality and Fairness* states that: *"The waiting list initiative has funded a large number of elective procedures and has enabled thousands of patients to receive treatment more quickly than*

would have been possible otherwise. Waiting times have been reduced substantially in a number of specialties. For example the number of adults waiting for longer than 12 months for cardiac surgery has reduced from 587 to 190 between June 2000 and June 2001; the number of children waiting for longer than 6 months for cardiac surgery has reduced from 66 to 10 in the same period” (2001:45).

- 6.17 However, many commentators have queried the overall impact of the Waiting List Initiative in the light of the performance of waiting lists and waiting times since 1993 described above. Certainly, it is not reassuring to find that the overall level of waiting lists increased through much of the period the WLI has been in operation and has subsequently only returned to the 1994 levels. Furthermore, the share of long-waiters remains higher than in 1996 when duration data was first collected. One possible factor in this is that, over most of the period since 1993, annual funding under the Initiative may have been insufficient to make a significant impact outside some key specialties. Funding was much larger in 2000 and was associated with a fall in the waiting list total. However, while funding in 2001 has been of a similar magnitude, the downward trend has not been maintained and waiting lists have plateaued after the first quarter. Overall, on the information available, the impact of the WLI is hard to determine and it has not been formally evaluated.

Waiting Times and Prioritisation

- 6.18 While the issue of waiting for hospital treatment is frequently discussed in terms of the numbers on waiting lists there is general agreement, in Ireland and elsewhere, that the primary concern is waiting time. The following statements are fairly representative:

*“To date the **number** of people on public waiting lists has received much greater public attention than the actual time for which they have to await treatment. This is perhaps inevitable but it does not focus on the true nature of the problem. In practical terms what matters to the patient is the length of time that he/she has to wait for treatment rather than the absolute length of the list” (Review Group, 1998:4).*

“Indisputably, the greatest problem with waiting lists in Ireland is the actual length of time spent waiting” (JCHC, 2001:8).

- 6.19 A greater focus on waiting times has led to policies that target long-waiters for treatment. The WLI in principle is targeted towards reducing long waits, though as we have seen its achievements in this regard are unclear. A number of countries have gone further and introduced ‘waiting time guarantees’.¹⁵ In 1992, for example, Sweden introduced a three-month guarantee for patients who

15. The remainder of this paragraph draws heavily on Sanmartin 2001.

passed a certain priority threshold across a range of specialties. The immediate results were fairly impressive but do not appear to have held up – or at least not to the same degree – over time. The UK Patients Charter also introduced a waiting time guarantee – within 18 months from the time of admission. This appears to have eliminated very long waits. New Zealand has introduced a 6-month guarantee for patients who meet certain priority criteria and, as noted earlier, it seems to have achieved impressive reductions in waiting lists and waiting times. However, it is important to note that in this case the guarantee was one element in a much wider strategy for managing waiting lists, which included developing a system of patient prioritisation and a national-booked admission system for elective admissions.

- 6.20 It is important to be clear about the policy implications of shifting from a focus on waiting lists to waiting times. The implications of waiting time policies depend on the specific characteristics of the waiting list to which they are applied. If a waiting list operates on a first come first served basis (assuming for simplicity that all patients have equal medical needs), then other things being equal all those in the queue will wait the same length of time which will be determined by the number of people waiting. Here a waiting time guarantee is equivalent to a commitment to reducing a waiting list through more investment or better management and there are no implications over and above the issues already discussed. However, if those on a waiting list face different waiting times, then the implications of a waiting time guarantee depend on the reasons for this variation.
- 6.21 To simplify greatly, one possibility is that waiting lists operate on a first come first served basis as above but other things are not equal. In the real world this could arise, because the waiting list in any specialty is made up of a range of different lists that may move at different speeds, i.e. are more or less efficient. Here a waiting list guarantee is a way of promoting best practice and in principle is relatively uncontroversial, if the guaranteed waiting time is a reasonable reflection of best practice. The implementation of a guarantee would then typically require a range of measures to promote better management of the waiting process – through benchmarking hospitals or consultants and so on. One example of this is the publication of individual level data on waiting lists and waiting times.
- 6.22 However, another reason why patients face different waiting times is that waiting lists are not in fact supposed to be organised on a first come first served basis. Instead, we rightly expect patients to be treated in order of their clinical priority. Here, giving priority to someone passing a duration threshold may mean that someone who is considered to have a higher clinical priority may have to wait longer than he or she might otherwise have done. In fact, there is some evidence that this has occurred in the UK. **Policies directed at reducing waiting times raise**

particular issues for equity of access as they are directly concerned with the criteria for prioritising patient access.

6.23 It is not surprising, therefore, to find that waiting time guarantees are typically linked to agreed standards for patient prioritisation. In Australia, for example, cases are classified into three categories by clinical urgency, and waiting time targets are set accordingly. Waiting prioritisation can also be pursued much further, either along with or independently of waiting time guarantees. Here, the crucial concern is to ensure that the waiting allocation is carried out on an equitable basis. It seems reasonable to suggest that the length of time that is acceptable should be related to the severity/urgency of the condition. However, this will only produce a fair allocation if there is reasonable standardisation of definitions of priority, yet there is evidence of widespread variation in medical practice in this as in many other areas.

6.24 The development of priority scoring systems in a range of specialties has been pursued in a number of countries including New Zealand (where it has been developed together with the booked admission system) and Canada. A major Canadian initiative in this area, the Western Canada Waiting List Project, has recently completed its work. There, as elsewhere, waiting times vary and are not always linked to severity of condition. David Hadorn, who has been centrally involved in these developments in both countries, describes the thrust of this approach as follows:

“The time-honoured method for denoting relative urgency on waiting lists has been to assign patients to one of a few broad categories such as ‘emergency’, ‘urgent’ and ‘routine’.... However the vagueness of such category descriptions does little to reduce the inherent subjectivity of global urgency judgements, nor is it possible using this approach to prioritise patients within each category.

An alternative and more powerful method for assessing and comparing patients relative urgency on waiting lists has been used in New Zealand for several years as part of a national project to replace waiting lists with booking systems. This method operates by assigning points to patients based on the severity of clinical findings (e.g. degree of pain or limitation in motion) and on considerations of expected treatment benefit. A similar approach is being tested in the UK. The Western Canada Waiting List Project has developed such measures in five clinical areas: MRI scanning, hip and knee replacement, cataract surgery, general surgery, and children’s mental health” (Hadorn, 2001: 444).

Conclusions

6.25 This Section has looked at policy in regard to waiting lists, in particular the experience with the Waiting List Initiatives which have been implemented in recent years.

6.26 The discussion has brought out first that the incentives implicit in such initiatives may have perverse features, and evidence from both Ireland and elsewhere on the long-term success of such measures is mixed. It has also highlighted that policies directed at reducing waiting times raise particular issues for equity in access across those waiting, since they are directly concerned with the criteria for prioritising patient access. Thus, for example, guarantees that patients will not have to wait for longer than a specified time have to be linked to agreed standards for patient prioritisation.

Section VII

Equity of Access in the New Health Strategy

Section VII: Equity of Access in the New Health Strategy

Introduction

7.1 In December last, the Government adopted a new medium-term (7-10 year) Health Strategy, entitled *Quality and Fairness: A Health System for You*. This Strategy covers all aspects of the health and personal social services. In this Report however the focus is firmly on equity of access and the public-private mix, and we now discuss the Strategy in terms of its treatment of this core issue. First, we discuss how the Strategy sees the issue of equity of access in general terms. We then look at how the Strategy aims to promote equity of access, and point to a range of concerns about its approach. We conclude by highlighting fundamental issues from the Forum's perspective which are taken-up again in Section VIII.

Equity of Access

7.2 The Strategy argues at the outset that the health system must be based on principles of equity and fairness, a people-centred service, quality of care and clear accountability. The document discusses equity with regard both to health inequalities and access to healthcare¹⁶ and states that equity will be central to developing policies (i) to reduce the difference in health status currently running across the social spectrum in Ireland; and (ii) to ensure equitable access to services based on need (2001:18).

7.3 In an examination of the problems in the current system, that of equity of access is specifically framed in terms of the contrast between public and private patients. *"The private sector makes an important contribution to services needs which must be harnessed to best effect for patients. One of the key concerns of the Health Strategy is to promote fair access to services, based on objectively assessed need, rather than on any other factor such as whether the patient is attending on a public or private basis. This is of particular concern in the area of acute hospital services. The current mix of public and*

16. *"People from the lower socio-economic groups suffer a disproportionate burden of ill health. The equity principle recognises that social, environmental and economic factors including deprivation, education, housing and nutrition affect both an individual's health status and his or her ability to access services. Access to health care should be fair. The system must respond to peoples needs rather than have access dependent on geographic location or ability to pay. A perceived lack of fairness and of equal treatment are central to many of the complaints made of the existing system. Improving equity of access will improve health by ensuring that people know what services they are entitled to and how to get those services and that there are no barriers, financial or otherwise, to receiving the services they need"*(2001:18).

private beds in the public hospital system is intended to ensure that the public and private sectors can share resources, clinical knowledge, skills and technology. This mix raises serious challenges, which must be addressed in the context of equity of access for public patients” (2001:43) and “The Strategy must address the ‘two-tier’ element of hospital treatment where public patients frequently do not have fair access to elective treatment. All such patients should have such access within a reasonable period of time irrespective of whether they are public or private patients...” (2001:48).

- 7.4 This discussion is summarised in the Strategy’s following ‘key message’ **“Access to services to be more equitable – the perceived two tier aspect of healthcare to be eliminated”** (2001: 57). How is this to be done?

Promotion of Action on Equity

- 7.5 *Quality and Fairness* addresses a medium-term perspective across all aspects of the health and personal social services. The Strategy sets out four overarching national goals. These are:

- 1 better health for everyone;
- 2 fair access;
- 3 responsive and appropriate care delivery; and
- 4 high performance.

These national goals are elaborated in terms of twelve objectives, which are set out below in Box 2. In the Strategy, each objective is then specified in terms of a series of actions, 73 in all.

- 7.6 Alongside these national goals/objectives/actions the Strategy states that *“the health system needs to be reformed and developed so that the national goals can be achieved”* (2001:93) and sets out six frameworks for change, in respect of: strengthening primary care; reform of the acute hospital system; funding; developing human resources; organisational reform, and information. These frameworks are again elaborated by setting out a further 48 actions, bringing the total number of actions to 121.
- 7.7 Our main concern here is with the goal of fair access. This is defined as *“concerned with making sure that equal access for equal need is a core value for the delivery of publicly funded services. Access in terms of timing and location are also embraced by this goal”* (2001:74). As we have seen, there are three objectives under this goal. Under the first and second of these, public entitlements for those with and without medical cards, will be clarified and codified in legislation in terms of entitlement rather than eligibility. In addition, they provide for widening the income limits for medical cards and for some specific additions to public provision.

Box 2 HEALTH STRATEGY'S GOALS AND OBJECTIVES	
National Goals	Objectives
1. Better health for everyone	<ul style="list-style-type: none"> – The health of the population is at the centre of public policy – The promotion of health and well-being is intensified – Health inequalities are reduced – Specific quality of life issues are targeted
2. Fair Access	<ul style="list-style-type: none"> – Eligibility for health and personal social services is clearly defined – Scope of eligibility framework is broadened – Equitable access for all categories of patient in the health system is assured
3. Responsive and appropriate care delivery	<ul style="list-style-type: none"> – The patient is at the centre of planning care delivery – Appropriate care is delivered in the appropriate setting – The system has the capacity to deliver timely and appropriate services
4. High Performance	<ul style="list-style-type: none"> – Standardised quality systems support best patient care and delivery – Evidence and strategic objectives underpin all planning and decision making

Source: Department of Health and Children, 2001.

7.8 The third objective, that 'Equitable access for all categories of patient in the health systems is assured', is explicitly directed at addressing 'two-tier' access:

"A core objective of this strategy is that all people should have access to high quality services. However it is clear that there are significant inequalities in the system at present which must be addressed, such as unacceptably long waiting times for public patients for some elective hospital procedures" and "All patients should have access to a high quality service, within a reasonable period of time, irrespective of whether they are public or private patients" (2001:74).

7.9 There are five actions set out under this objective. Four of these cover actions on availability of information, the physical accessibility of health facilities, appointment planning and upgrading waiting areas. The remaining action, which is of a different order, is:

"Improved access to hospital services for public patients will be addressed through a series of integrated measures. These measures, discussed in Chapter 5 [i.e. the frameworks for change], are designed to reduce substantially the waiting times for

public patients for elective treatments. Specific targets are set so that by the end of 2004, no public patient will have to wait for more than three months to commence treatment, following referral from an out-patient department” (2001:78).

Reform of the Acute Hospital System

7.10 Turning to the ‘frameworks for change’, the framework of most relevance here is that for reform in acute hospitals. Here the Strategy states again:

“The overall policy objective for the reform of acute hospitals is improving access for public patients. The reforms involve increasing capacity through further investment, strengthening efficiency and quality of services, and working in closer partnership with the private hospital sector” (2001:93).

7.11 The Strategy provides for the setting up of a National Hospital Agency. This Agency will not be involved in ownership or day-to-day operation of hospitals. Rather it will have a planning role in relation to the development of the acute hospital systems and national specialist services, and will take a lead role in waiting list management and in developing ‘a strategic relationship’ with the private sector (see below). The Strategy envisages that this will free up the Health Boards to concentrate on other important aspects of their work.

7.12 The Strategy adopts the following specific targets for waiting times:

- by the end of 2002, no adult will wait longer than twelve months and no child will wait longer than six months to commence treatment following referral from an out-patient department;
- by the end of 2003, no adult will wait longer than six months and no child will wait longer than three months to commence treatment following referral from an out-patient department; and
- by the end of 2004, no public patients will wait longer than three months for treatment following referral from an outpatient department.

7.13 The main actions for acute hospitals that are expected to deliver on these targets can be summarised in five principal measures.

7.14 Firstly, acute hospital capacity will be increased and targeted more firmly towards acute public patients. The Strategy states that 3,000 new acute beds will be added to the health system over the next ten years, of which 650 will be provided in 2002. Not all these beds will be in the publicly funded hospital sector. In 2002, 200 beds in private hospitals will be contracted for public use. Beyond 2002, the document does not indicate when the remaining 2,350 planned beds will come on stream nor does it give any breakdown of how many of the remaining beds will be provided in the public sector and contracted from the private sector

respectively. It does state that *“The Government is committed to exploring fully the scope for the private sector to provide additional capacity”* and that a Forum involving the public and private sectors and insurers will be set up under the new National Hospitals Agency to develop a strategic partnership with the private hospital sector.

- 7.15 The Strategy emphasises that the priority is to increase access *for public patients*. Therefore, all additional beds (other than Intensive Care Unit and similar specialised beds which will continue to be non-designated) will be designated solely for public patients.
- 7.16 Secondly, much more active waiting list/times management will be promoted. The National Hospitals Agency will manage a new national waiting times database. The data will be used to inform referrals by making individual consultant waiting lists data available to GPs on a dedicated intranet site. The data will also underpin the operation of a new treatment purchase fund to be established (see below). In addition, guidelines will be developed for referral and prioritisation of patients within and between specialties, especially those with long waiting times. This will be led by the Hospitals Agency, with the Health Boards/ERHA and in consultation with professional bodies. It is intended that *“the guidelines will assist general practitioners in making referrals in keeping with best clinical practice and consultants in managing waiting lists/times”* (2001:104).
- 7.17 Thirdly, a new Treatment Purchase Fund is being set up. (Budget 2002 allocated €30m to this purpose). This Fund will be used to purchase treatment for public patients who have been waiting over three months *“until the target of treatment within three months is met by the end of 2004”* (2001:101). A dedicated Treatment Purchase Team will purchase treatments from private hospitals in Ireland, and from providers in other countries. It may also make use of any capacity within public hospitals to arrange treatment for patients.
- 7.18 Fourthly, the balance between public and private practice in public hospitals will be managed to support timely access for public patients. There are a number of elements here. The bed designation arrangements will be clarified and fully implemented. In the context of forthcoming negotiations on the common contract, the Government will propose that newly-appointed consultants would work exclusively for public patients for a period of time while having the right to private practice thereafter.
- 7.19 Finally, *“Action may be taken to suspend admission of private patients for elective treatment if the maximum target waiting time for public patients is exceeded”* (2001:108). This will apply at the speciality level. It is envisaged that hospitals could be directed to suspend private admissions in a speciality until the target waiting time is restored. *“This direction can be set aside if hospital management and the*

consultants can agree on alternative means of restoring the target waiting time” (2001:108).

7.20 While these are the main direct measures set out in the Strategy, other measures would also contribute. These include measures to improve patient management and discharge, and the provision of facilities outside the acute system would relieve pressure on acute hospitals. In addition, wider reforms in areas such as developing the casemix system of funding allocation should enhance hospital efficiency.

Forum’s Assessment of the Health Strategy’s Provisions on Equity of Access

7.21 At the outset we welcome the new Strategy’s forthright recognition that the glaring inequalities of access between public and private patients must be addressed as a priority.

7.22 At the same time, the Forum also welcomes the emphasis in the Government’s parallel document *Primary Care – A New Direction* to increased investment and priority for the development of primary care in the community, given its potential for the greatest health gain. The objective of achieving a shift in resources towards a better balance between hospital and primary care also has the potential to provide, in a community setting, greater equity and support for the most vulnerable groups in our society.

7.23 In practical terms, the Strategy defines the problem to be addressed as reducing waiting times faced by public patients. As we have seen (Section IV above), the equation of equity of access with shorter public waiting times has characterised public policy debate at least since the Commission on Health Funding. What is new in this Strategy is the development of this approach – which here moves well beyond the position taken in Government policy to-date.

7.24 This is most obviously the case with the targets adopted in *Quality and Fairness*. Almost since the inception of the current Waiting List Initiative, the stated – and as yet unachieved – objective by successive Governments has been to eliminate waits over twelve months for adults and over six months for children. This Strategy sets a target of eliminating these very long waits by the end of 2002. Furthermore, the overall target is that by the end of 2004, no-one will wait longer than three months between out-patient appointment and treatment. As our national waiting lists only include those who have been waiting for three months (see Section V), this target implies the elimination of waiting lists as we have known them by that date.

- 7.25 The Forum has always supported the adoption of ambitious and challenging targets in addressing significant policy problems. In earlier work we advocated 'Ending Long-term Unemployment' at a time when long-term unemployment was seen by many as 'part of what we are'. In our view such targets help break the hold of fatalism, provide a focus for mobilising and co-ordinating the efforts of stakeholders behind a common goal, and thus can help to bring about real progress even in relation to hitherto intractable policy problems. Not surprisingly then, with regard to long term waiting for access to acute hospital, we believe that bold targets – as are those adopted in this Strategy – can provide an essential starting point.
- 7.26 For targets to play an energising role they must be both challenging and credible. The actions put in place to meet them must also be credible and firmly carried out. In our earlier discussion of waiting list policy (Section VI) we suggested that waiting lists must be addressed by a combination of:
- (a) planning the underlying capacity of the system with the objective of matching current demand and supply; this avoids the creation of waiting lists, or stabilises existing lists by matching inflows and outflows; and
 - (b) mobilising additional – possibly temporary – capacity to eliminate the waiting list backlog or at least to reduce it to an acceptable level.
- 7.27 *Quality and Fairness* addresses both these strands. The planned increase of 3,000 beds over the next decade is based on an analysis of the bed capacity and projected future requirements. We note that any projection exercise will need to be refined and reworked in the light of changes over time and we would recommend on-going work in this area be undertaken and/or commissioned by the Department as an essential input to future service planning. In the short term, the Government has recently announced that there will be an additional 709 acute beds in public hospitals this year (2002) rather than the 450 announced in the Strategy. With the 200 beds expected to be provided for public beds by private hospitals, this would bring the total additional beds this year to 909 rather than the Strategy's figure of 650. However, doubts have been expressed on the feasibility of achieving these increases, given the already high level of nursing vacancies that are remaining unfilled at present.
- 7.28 In regard to additional capacity, the Strategy sets up a new Treatment Purchase Fund (TPF) to buy treatment from the private sector, both here and abroad, for public patients on lengthy waiting lists. The flow approach discussed in Section VI suggests that in principle waiting lists can be significantly reduced through special initiatives which mobilise additional – possibly temporary – capacity and as we discussed briefly in Section V, at least some of the international experience would seem to bear this out. However, an Irish Waiting List Initiative has been in place since 1993 and its overall impact on waiting lists or even on those waiting

longest is, to say the least, hard to determine. While we considered a number of possible reasons for this, the absence of any formal evaluation of this Initiative, makes any definite conclusion impossible.

- 7.29 On the limited information available to date, the design of the new initiative seems to be more transparent and more directly tied to waiting list reduction than the existing WLI, and this is to be welcomed. We recommend that formal evaluation of this initiative should be built in from the outset in order to support ongoing policy development in this area. It is also important to note that the resources allocated to the new TPF initiative will be additional to those available under the WLI. This must be seen in the context of the target of eliminating waiting over twelve months for adults or six months for children this year. However, it might be recalled that commitments to exactly these same targets were already given in the Government's 1999 White Paper on Private Insurance.
- 7.30 Questions have also been raised on the capacity of the private sector to deliver, as well as on a number of other operational issues such as how follow-up after-care for those who will have been treated abroad will be handled.
- 7.31 We welcome and support in particular the recognition in the Strategy to the effect that ... *"This (public-private) mix raises serious challenges which must be addressed in the context of equity of access for public patients"*. However, one of the criticisms made is that the Strategy does not address these challenges to equity adequately. Indeed, our study of other systems indicates that inequities may only be addressed by structural reform. There is a need, therefore, to consider possible structural changes which may prove beneficial to address the principle of equity which the Strategy indicates is a key to the health system in this country. In this regard, particular attention should be given to the way some European systems address these issues, including that of funding.
- 7.32 For any given level of capacity in the public system, its allocation between public and private patients is by definition a determinant of the level of service available to the public patient. This issue arises with regard to the physical capacity of the hospital – beds – and in respect of the allocation of consultant time. In an important and most welcome break with earlier practice, additional bed capacity provided from the public purse is to be designated exclusively for public patients. In addition, the Strategy seeks to maximise the capacity available to public patients by firmly implementing the designated bed allocations.
- 7.33 In regard to consultants' time, the rules governing individual consultant's allocation of their time between public and private patients are to be clarified and more clearly implemented, and the Forum would support this. Furthermore, in this regard, the Forum wishes to highlight the importance of ensuring that Accident & Emergency Departments in strategically-based acute

hospitals should be adequately staffed with specialist (consultant) teams on a 24-hour basis. This would help to alleviate problems under the present system where junior medical personnel, alone for many hours at a time, staff these Departments but are unable to take responsibility to discharge patients who could otherwise be let home.

- 7.34 In addition, the Government is proposing changes in the Consultant Contract under which new consultants would not engage in private practice for a number of years. Furthermore, the Strategy clearly signals that public hospitals must give greater priority to timely access (i.e. within the targets set by the Strategy) for public patients, and achievement of this priority may sometimes require further, albeit temporary, limits on private admissions to public hospitals.
- 7.35 All of these proposals will, if rigorously acted on and implemented, have a critically key role to play in delivering on the Strategy's objectives. Past experiences should have taught us that repeating the piecemeal pragmatic approaches of the past will again be self-defeating as long as the structural problems of the system are not adequately addressed.
- 7.36 Overall then, we believe that the approach set out in the Strategy can bring about a real improvement in the position of public patients. Nevertheless, we have a number of serious concerns about the implementation of the Strategy, and we believe the need for greater structural reform in the public-private mix has to be addressed. These concerns are now set out.
- 7.37 **Firstly**, the Strategy only addresses one – very important – element of the time spent waiting on the pathway to care. Part of the problem facing public patients is lengthy waits for first consultant appointment after referral by a GP, but this issue is not recognised or addressed by the Strategy. At the very least those implementing the Strategy must be in a position to ensure that the waiting list targets are not met through 'wait shifting' – i.e. reducing waits between out-patient consultation and treatment by increasing waits between GP referral and out-patient consultation. This will require systematic measuring and monitoring of waiting at all points on the pathway to treatment. However, beyond this immediate issue the inequity between public and private patients in the waiting times they face for initial specialist appointments must itself be addressed.
- 7.38 **Secondly**, the commitment to timely access for public patients requires that policy commitments in this area must be underpinned by legislation. As noted above, the Strategy provides that public entitlements for those with and without medical cards will be clarified and codified in legislation, in terms of entitlement rather than eligibility. In our view it is essential, however, that this legislation should also guarantee rights to treatment within a reasonable period. This must, of course, take into account the limits of the public resources available for the

health services and the separation of judicial and executive powers under our Constitution. Moreover, the Government's new *Health Promotion Strategy 2000 - 2005* is aimed at encouraging people to adopt healthier lifestyles.

- 7.39 In short, and in line with the recommendation of the UN Committee on Economic, Social and Cultural Rights the objective should be that everybody has the opportunity for maximum health gain and enhancement through public policies, supportive environments, and access to appropriate services when needed.
- 7.40 **Thirdly**, as we have discussed above, the Strategy signals that public hospitals must give greater priority to timely access (i.e. within the targets set by the Strategy) for public patients, and achievement of this priority may sometimes require delaying private admissions. The Forum fully supports this approach. However we are concerned that no specific commitment is made to ensure that all admissions to public hospitals – whether public or private – should be prioritised in accordance with medical need, and not that of ability to pay. In other words, we believe that at a minimum, access to public hospitals should be on the basis of a common waiting list, otherwise the underlying inequality in the system will continue.
- 7.41 **Fourthly**, one peculiarity in the Irish case, for example, is that the Government is turning to private suppliers to provide capacity for public patients, while dedicating some 20 per cent of existing public capacity to private patients. Greater use of private suppliers should not, however, be such as to undermine the primacy of the State's role in the provision of public health. In this respect, the Department of Health and Children should, within the framework of the SMI's Quality Customer Service (QCS) Initiative and the work of the Health Service Quality Assurance Group under the *Programme for Prosperity and Fairness* (PPF), establish quality standards for delivery and appropriate regulatory mechanisms to ensure that these are complied with. It would be essential, of course, that there should be uniformity in standards and that the same standards should apply both in the private as well as in the public sectors.
- 7.42 **Fifthly**, the Forum would emphasize the importance of adopting a fully-fledged partnership approach in the implementation of the Strategy, between providers, administrators and patients, and the involvement of the Social Partners. Facilitating and encouraging participation and involvement by the local community and voluntary groups are particularly important in this regard.
- 7.43 **Finally**, a broader but fundamental question about the Strategy's treatment of equity of access must be raised. If all the targets set out in the Strategy are achieved and maintained the question remains does that constitute full equity of access to acute hospital care in Ireland? Equity of access has indeed been widely

equated with shorter public waiting times, and the new Health Strategy carries this through to its logical conclusion. (It may not however do full justice to the concept). Success in terms of the Strategy's targets would entail shorter waiting times for public patients – sometimes very much shorter – than at present, but public patients might well still have to wait longer for essential treatment than private patients and not necessarily be treated in the same way when in hospital.

- 7.44 This is currently seen by many as a result of the structure of the Irish public hospital system, with its unusual inter-mingling of public and private, which the Strategy essentially leaves unchanged. The Forum regards the current public-private mix as a significant issue in relation to equity and believes that there is a requirement to examine, taking into account the actions in the Strategy and the Report on Review of Bed Capacity in particular, structural change which may be necessary to ensure that patients are dealt with on an equitable footing, and that incentives to providers are clearly aligned with that perspective.
- 7.45 Although funding of the health services has doubled over the last few years, only one-third of these resources have gone on new developments. The Forum wishes to emphasise, therefore, that additional resources will not be sufficient in themselves but must also be complemented and reinforced with parallel moves on the structural deficiencies (and indeed the managements weaknesses in the system pinpointed in the recent Deloitte & Touché *Value for Money Audit of the Irish Health System* report). Unless these are tackled more decisively and the system more radically overhauled, the feasibility of delivering on the Health Strategy's goals and objectives will be seriously undermined.

Section VIII

Achieving Equity of Access to Hospital Care

Section VIII: Achieving Equity of Access to Hospital Care

- 8.1. In approaching the design and delivery of health care, equity in access must be a fundamental principle, and is one to which the Forum, reflecting its mandate, gives the highest priority. A critically important role for the State is to act as guarantor in the availability of a satisfactory level of health care to **all** its citizens, irrespective of means.
- 8.2. The Forum very much welcomes the increasing resources now being made available to the public healthcare system, and believes that these, together with innovations in policy at both primary care and hospital levels, can bring about a real improvement in the position of public hospital patients and contribute to reducing their waiting times. Nevertheless, we believe that increased capacity and efficiency and increased emphasis on the needs of public patients, however welcome, may not suffice to bring about equity in access to hospital care.
- 8.3. As mentioned in the previous Section of the Report, the Forum regards the current public-private mix as a significant issue in relation to equity. We believe, therefore, that there is a requirement to examine, taking into account the actions in the Strategy and the National Review of Acute Hospital Bed Capacity in particular, structural change which may be necessary to ensure that patients are dealt with on an equitable footing, and that incentives to providers are clearly aligned with that perspective.
- 8.4. Alternative models can be seen in other countries (see Sections III and V), which do not have the same problems as we do from an equity perspective. None of these systems is perfect, and reform to be successful must take as its starting-point the way our current system has evolved, rather than trying to design a blueprint *ab initio*. None the less, the Forum believes that there is much to be learnt from these alternative structures, and recommends that an independent investigation of structural alternatives should be given the highest priority, as planned reforms within our current public-private structure proceed.
- 8.5. Moving away from a two-tier system within public hospitals must not, of course, simply lead to an inadequate public hospital system for the poor, while the better-off avail of private care and are encouraged to do so by various forms of State subsidy. Instead, the State must guarantee and ensure the availability of adequate health care to all its citizens regardless of means, and the Forum

believes that this is the only way that equity of access to hospital care can be achieved.

- 8.6 Finally, we would suggest that follow-up on the above study should be pursued by the Inter-Departmental Committee of senior officials that will review the implementation and impact of the Strategy on an on-going basis. The structures to monitor the implementation of the targets of the revised National Anti-Poverty Strategy, which was published recently by the Government, should also address these issues. Other institutional mechanisms would include the proposed Health Information Quality Authority and the National Hospital Authority and the Service Planning Framework in the Health Boards.

Annexes

Annex I: Statistical Data

Trends in Expenditure

Annex Table 2.1: Expenditure on Health in Ireland, 1989 - 2000

Year	OECD	Public €m (%)	Private €m (%)	Dept. of Health and Children		
	Total €m			Total €m	Public €m (%)	Private €m (%)
1989	2,143	1,533 (71.5)	611 (28.5)	2,402	1,790 (74.5)	612 (25.5)
1990	2,443	1,751 (71.7)	692 (28.3)	2,614	1,967 (75.2)	648 (24.8)
1991	2,691	1,966 (73.1)	725 (26.9)	2,868	2,178 (75.9)	691 (24.1)
1992	3,059	2,194 (71.7)	865 (28.3)	3,277	2,435 (74.3)	843 (25.7)
1993	3,294	2,399 (72.8)	895 (27.2)	3,521	2,683 (76.2)	838 (23.8)
1994	3,567	2,556 (71.7)	1,011 (28.3)	3,812	2,876 (75.4)	936 (24.6)
1995	3,846	2,797 (72.7)	1,049 (27.3)	4,097	3,102 (75.7)	994 (24.3)
1996	4,111	2,979 (72.5)	1,133 (27.5)	4,285	3,201 (74.7)	1,086 (25.3)
1997	4,525	3,394 (75.0)	1,131 (25.0)	4,782	3,671 (76.8)	1,111 (23.2)
1998	4,727	3,584 (75.8)	1,143 (24.2)	5,295	4,073 (76.9)	1,223 (23.1)
1999	5,092	3,923 (77.1)	1,168 (22.9)	6,281	4,873 (77.6)	1,408 (22.4)
2000	n.a.	n.a.	n.a.	7,396	5,705 (77.1)	1,690 (22.9)

Source: OECD (2000) and the Department of Health and Children.

Trends in Waiting Lists

Appendix Table 5.1 Waiting List by Speciality
end-December 1996 to end-December 2000

	1996	1997	1998	1999	2000
<i>(a) Totals</i>					
E.N.T.	5,291	7,138	7,722	7,486	5,690
Orthopaedics	4,975	6,432	7,344	6,304	4,486
Ophthalmology	2,401	3,002	4,309	4,475	3,253
Other	1,580	1,740	2,171	3,271	2,897
Surgery	2,614	2,958	3,460	3,405	2,711
Vascular	2,361	2,726	2,797	2,730	2,289
Plastic Surgery	1,004	1,720	2,057	2,401	2,204
Urology	1,556	1,604	1,530	1,901	1,451
Gynaecology	1,931	2,216	3,016	2,571	1,385
Cardiology	792	1,299	1,248	1,109	946
Cardiac Surgery	1,454	1,371	1,229	1,202	545
All	25,959	32,206	36,883	36,855	27,857
<i>(b) Index</i>					
E.N.T.	100	135	146	141	108
Orthopaedics	100	129	148	127	90
Ophthalmology	100	125	179	186	135
Other	100	110	137	207	183
Surgery	100	113	132	130	104
Vascular	100	115	118	116	97
Plastic Surgery	100	171	205	239	220
Urology	100	103	98	122	93
Gynaecology	100	115	156	133	72
Cardiology	100	164	158	140	119
Cardiac Surgery	100	94	85	83	37
All	100	124	142	142	107

Source: Department of Health and Children.

**Appendix Table 5.2 Adults and Children by Duration on the Waiting List
end-December 1996 to end-December 2000**

	1996	1997	1998	1999	2000
<i>(a) Totals</i>					
Adults 3-12 months	11,837	13,320	15,187	13,995	10,786
Adults 12 months+	8,596	11,922	14,928	14,833	10,337
Child 3-6 months	1,103	1,683	1,056	928	745
Child 6 months+	2,040	2,242	2,923	2,719	2,146
All	23,576	29,167	34,094	32,475	24,014
<i>(b) Index</i>					
Adults 3-12 months	100	113	128	118	91
Adults 12 months+	100	139	174	173	120
Child 3-6 months	100	153	96	84	68
Child 6 months+	100	110	143	133	105
All	100	124	145	138	102

Source: Department of Health and Children.

Appendix Table 5.3: Adults Over 12 Months on the Waiting List by Speciality, end-December 1996 to end-December 2000

	1996	1997	1998	1999	2000
<i>(a) Totals</i>					
E.N.T.	1,124	1,937	2,864	3,040	2,469
Orthopaedics	2,188	3,037	3,615	3,704	2,007
Vascular	1,158	1,781	1,931	1,807	1,488
Plastic Surgery	467	883	942	1,080	1,141
Surgery	666	1,110	1,063	1,069	881
Urology	560	802	829	901	821
Ophthalmology	647	803	1,199	1,617	807
Gynaecology	396	600	1,079	799	453
Cardiac Surgery	1,030	969	776	816	2,70
All	8,236	11,922	14,298	14,833	10,337
<i>(b) Index</i>					
E.N.T.	100	172	255	270	220
Orthopaedics	100	139	165	169	92
Vascular	100	154	167	156	128
Plastic Surgery	100	189	202	231	244
Surgery	100	167	160	161	132
Urology	100	143	148	161	147
Ophthalmology	100	124	185	250	125
Gynaecology	100	152	272	202	114
Cardiac Surgery	100	94	75	79	26
All	100	145	174	180	126

Source: Department of Health and Children.

Appendix Table 5.4 Adults Over 12 Months on the Waiting List as a percentage of Waiting List, by Speciality end-December 1996 to end-December 2000

	<i>1996</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>
Plastic Surgery	58	62	57	59	68
Vascular	64	65	69	66	65
E.N.T.	40	47	58	58	62
Urology	37	50	55	49	57
Cardiac Surgery	74	76	67	73	54
Orthopaedics	45	48	50	60	47
Surgery	27	40	32	34	34
Gynaecology	20	27	36	31	33
Ophthalmology	30	29	30	39	27

Source: Department of Health and Children.

Appendix Table 5.5: Children Over 6 Months on the Waiting List by Speciality, end-December 1996 to end-December 2000

	1996	1997	1998	1999	2000
<i>(a) Totals</i>					
E.N.T.	1,524	1,714	2,143	1,688	1,347
Plastic Surgery	157	218	257	445	436
Ophthalmology	162	101	256	269	169
Orthopaedics	53	89	88	64	86
Surgery	69	48	101	147	69
Cardiac Surgery	55	66	57	67	29
Urology	20	6	12	36	9
All	2,040	2,242	2,914	2,716	2,145
<i>(b) Index</i>					
E.N.T.	100	112	141	111	88
Plastic Surgery	100	139	164	283	278
Ophthalmology	100	62	158	166	104
Orthopaedics	100	168	166	121	162
Surgery	100	70	146	213	100
Cardiac Surgery	100	120	104	122	53
Urology	100	30	60	180	45
All	100	110	143	133	105

Source: Department of Health and Children.

Appendix Table 5.6: Children Over 6 Months on the Waiting List as a Percentage of Waiting List, by Speciality, end-December 1996 to end-December 2000

	1996	1997	1998	1999	2000
Plastic Surgery	80	72	65	78	84
E.N.T.	62	57	76	76	80
Ophthalmology	64	44	71	81	69
Cardiac Surgery	100	68	78	76	67
Urology	77	40	57	62	47
Surgery	64	30	58	53	45
Orthopaedics	83	88	81	64	36

Source: Department of Health and Children.

Annex II:

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Terms of Reference and Constitution of the Forum

1. The main task of the Forum will be:
 - to monitor and analyse the implementation of specific measures and programmes identified in the context of social partnership agreements, especially those concerned with the achievement of equality and social inclusion;
 - to do so through consideration of reports prepared by teams comprising the social partners, with appropriate expertise and representatives of relevant Departments and agencies and its own Secretariat;
 - with reports to be published by the Forum with such comments as may be considered appropriate; and
 - to ensure that the teams compiling such reports take account of the experience of implementing bodies and customers/clients, including regional variations in such experience.
2. The Forum may consider such policy issues on its own initiative or at the request of the Government.
3. Membership of the Forum will comprise representatives from the following four strands:
 - the Oireachtas;
 - employer, trade unions and farm organisations;
 - the voluntary and community sector; and
 - central government, local government and independents.
4. The terms of office of members will be for an initial period of at least two years during which alternates may be nominated. Casual vacancies will be filled by the nominating body or the Government as appropriate and members so appointed shall hold office until the expiry of the current term of office of all members. Retiring members will be eligible for re-appointment.
5. The Chairperson and Deputy Chairperson of the Forum will be appointed by the Government.
6. The Forum will decide on its own internal structures and working arrangements.

7. The Forum will be under the aegis of the Department of the Taoiseach and funded through a Grant-in-Aid which will be part of the overall Estimate for that Department. The Annual Accounts of the Forum will be submitted for audit to the Comptroller and Auditor General.

8. Finally, the staffing and conditions of employment of the Forum's Secretariat will be subject to the approval of the Department of the Taoiseach.

Membership of the Forum

Independent Chairperson: Maureen Gaffney

Deputy Chairperson: Mary Doyle

(i) Oireachtas

Fianna Fáil:

Noel Ahern T.D.
Seán Haughey T.D.
Beverley Cooper-Flynn T.D.
Michael Kitt T.D.
Senator Margaret Cox
Senator Paschal Mooney

Fine Gael:

Gerry Reynolds T.D.
Paul McGrath T.D.
Bill Timmins T.D.
Senator Mary Jackman
Senator Therese Ridge

Labour:

Derek McDowell T.D.
Senator Joe Costello

Progressive Democrats:

Senator Jim Gibbons

Independents:

Michael Lowry T.D.

(ii) Employer/Trade Unions/Farm Organisations

(a) Employer/Business Organisations:

IBEC:

Jackie Harrison
Aileen O'Donoghue

Small Firms Association:

Pat Delaney

Construction Industry Federation:

Mirette Corboy

Chambers of Commerce/Tourist Industry
/Exporters Association:

Carmel Mulroy

(b) Trade Unions:

Eamonn Devoy
Blair Horan
Jerry Shanahan
Manus O'Riordan
Paula Carey

(c) *Agricultural/Farming Organisations:*

Irish Farmers Association:	Betty Murphy
Irish Creamery Milk Suppliers Association:	Pat O'Rourke
Irish Co-Operative Organisation Society:	Seamus O'Donoghue
Macra na Feirme:	Eileen Doyle
Irish Country Women's Association:	Breda Raggett

(iii) Community and Voluntary Sector

<i>Womens Organisations:</i>	Gráinne Healy Susan McNaughton Joanna McMinn
<i>Unemployed:</i>	Eric Conroy Joan Condon Mary Murphy
<i>Disadvantaged:</i>	Joe Gallagher Frances Byrne Janice Ransom
<i>Youth:</i>	Marian Brattman
<i>Older People:</i>	Paddy Donegan
<i>Disability:</i>	John Dolan
<i>Environment:</i>	Jeanne Meldon
<i>Others:</i>	Fr. Seán Healy Audry Deane

(iv) Central Government, Local Government and Independents

(a) Central Government

Secretary-General, Department of Finance
Secretary-General, Department of Enterprise, Trade and Employment
Secretary-General, Department of Social, Community and Family Affairs
Secretary-General, Department of Tourism, Sport and Recreation
Secretary-General, Department of the Environment and Local Government

(b) Local Government

General Council of County Councils:

Councillor Constance Hanniffy
Councillor Tom Kelleher
Councillor Patsy Treanor

Association of Municipal Authorities:

Councillor Tadhg Curtis

County and City Managers Association:

Donal O'Donoghue

(c) Independents

Professor Gearóid Ó Tuathaigh, National University of Ireland, Galway

Ms. Marian Vickers, Northside Partnership

Ms. Helen Johnston, Surg Equipment Ltd.

Mr. Niall Fitzduff, Rural Communities Network

Ms. Noreen Kearney, Trinity College, Dublin

Secretariat

Director:

Seán Ó hÉigeartaigh

Policy Analysts:

David Silke

Laurence Bond

Sarah Craig

Executive Secretary:

Paula Hennelly

Forum Publications

(i) Forum Reports

<i>Report No.</i>	<i>Title</i>	<i>Date</i>
1.	<i>Negotiations on a Successor Agreement to the PESP</i>	November 1993
2.	<i>National Development Plan 1994 – 1999</i>	November 1993
3.	<i>Commission on Social Welfare – Outstanding Recommendations</i>	January 1994
4.	<i>Ending Long-term Unemployment</i>	June 1994
5.	<i>Income Maintenance Strategies</i>	July 1994
6.	<i>Quality Delivery of Social Services</i>	February 1995
7.	<i>Jobs Potential of Services Sector</i>	January 1996
8.	<i>First Periodic Report on the Work of the Forum</i>	June 1995
9.	<i>Jobs Potential of Work Sharing</i>	January 1996
10.	<i>Equality Proofing Issues</i>	February 1996
11.	<i>Early School Leavers and Youth Unemployment</i>	January 1997
12.	<i>Rural Renewal – Combating Social Exclusion</i>	March 1997
13.	<i>Unemployment Statistics</i>	May 1997
14.	<i>Self-Employment, Enterprise and Social Inclusion</i>	October 1997
15.	<i>Second Periodic Report on the Work of the Forum</i>	November 1997
16.	<i>A Framework for Partnership – Enriching Strategic – Consensus through Participation</i>	December 1997

<i>Report No.</i>	<i>Title</i>	<i>Date</i>
17.	<i>Enhancing the Effectiveness of the Local Employment Service</i>	March 2000
18.	<i>Social and Affordable Housing and Accommodation: Building the Future</i>	September 2000
19.	<i>Alleviating Labour Shortages</i>	November 2000
20.	<i>Lone Parents</i>	July 2001
21.	<i>Third Period Report on the Work of the Forum</i>	November 2001
22.	<i>Re-integration of Prisoners</i>	January 2002
23.	<i>A Strategic Framework for Equality Issues</i>	March 2002
24.	<i>Early School Leavers</i>	March 2002
25.	<i>Equity of Access to Hospital Care</i>	April 2002

(ii) Forum Opinions

<i>Opinion No.</i>	<i>Title</i>	<i>Date</i>
1.	<i>Interim Report of the Task Force on Long-term Unemployment</i>	March 1995
2.	<i>The National Anti-Poverty Strategy</i>	January 1996
3.	<i>Long-term Unemployment Initiatives</i>	April 1996
4.	<i>Post PCW Negotiations – A New Deal?</i>	August 1996
5.	<i>Employment Equality Bill</i>	December 1996
6.	<i>Pensions Policy Issues</i>	October 1997
7.	<i>Local Development Issues</i>	October 1999
8.	<i>The National Anti-Poverty Strategy</i>	August 2000

(iii) Forum Opinions under the Monitoring Procedures of Partnership 2000

<i>Opinion No.</i>	<i>Title</i>	<i>Date</i>
1.	<i>Development of the Equality Provisions</i>	November 1997
2.	<i>Targeted Employment and Training Measures</i>	November 1997