Irish Cancer Society

OVERVIEW

The Irish Cancer Society welcomes the opportunity to engage with the Department of Health through the consultation on introducing a fuller minimum range of services provided by GPs under private health insurance (PHI) contracts.

In our Strategic Statement '*Towards a future without cancer'* 2013-2017, we focused on the prevalence of health inequalities and how they contribute to the rising rate of cancer in Ireland. We believe that a move towards a single-tier system that does not discriminate patients' access to services based on their socio-economic position should be pursued and supported. The Irish Cancer Society considers fair and equitable access routes to healthcare and progressive health system financing is crucial to this country's health care reform.

The number of cancers diagnosed in Ireland is rising. We expect that 43,000 people a year will be diagnosed with a new cancer case in 2020. The number of people surviving cancer is also rising – almost 60% of people will live for 5 years or longer post-diagnosis. But cancer is not the only challenge our health system faces; the incidence of all other chronic diseases is increasing alongside other health problems such as diabetes and obesity. In order to manage these challenges, significant shifts in the delivery of healthcare will be needed. Some progress has already been made on moving from inpatient to day-case treatment in hospitals, but more needs to be done to shift from hospital treatment to primary and community settings.

Therefore, the Irish Cancer Society welcomes the thinking behind elements of this consultation whereby more patients would be treated by their GP than in hospital, but the inequity enshrined in the approach we have been asked to consider is contrary to the fundamental ethos of this organisation.

While we acknowledge that reforming the health services has to start somewhere, the Irish Cancer Society would like to see a clear roadmap of how the proposition that GP cover is included on private health insurance policies will result in a fairer healthcare system.

We have some far reaching concerns that the proposal would result in a wider divide between those who have and those who have not. If private health insurers are required by law to provide GP access on every policy, negative externalities could include: preferential treatment by GPs of people who have private insurance over those with neither a medical card nor PHI; over-utilisation of GP services caused by moral hazard which may create waiting lists for GPs and; this approach appears to reinforce the historical approach in Ireland of paying disproportionate attention to PHI holders, when those without medical card or PHI and medical card holders experience the worst access to care and likely the worst outcomes. Even if the long term plan is for Universal Health Insurance, the time it will take to overhaul the delivery of healthcare in Ireland and to agree a working funding mechanism, would mean that those with PHI policies would be at significant advantage to those without, during the intervening period.

For these reasons, and others we will mention in our submission, the Irish Cancer Society cannot support the introduction a fuller minimum range of services provided by GPs under health insurance contracts unless all citizens of Ireland receive the same benefit at the same time, while the Government also makes significant Government investment in primary care resources and infrastructure.

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CONTRARY TO GOVERNMENT POLICY

Government health policy has consistently stated that a primary objective is to reduce health inequalities. Recent publications that convey this message include:

- Future Health
- Healthy Ireland
- Tobacco Free Ireland
- A Strategy for Cancer Control in Ireland

A commitment to providing for GP care without fees was contained in the briefing note given to Minister Varadkar when he became Minister for Health in 2014:

> The Programme for Government made a commitment to reform the current public health system by developing a universal, single-tier health service, supported by Universal Health Insurance, which guarantees access to medical care based on need, not income. Preparations for the introduction of Universal Health Insurance include the introduction of legislation to extend GP services without fees. The Government is committed to introducing, on a phased basis, a universal GP service without fees (by 2016) within its term of office as set out in the Programme for Government and the Future Health strategy framework. This Government is the first in the history of the State to commit itself to implementing a universal GP service for the entire population.

The Irish Cancer Society recognises that the Minister for Health has to give consideration to all *'approaches, timing, administrative and financial implications of a range of options with a view to bringing developed proposals to Government'*, but we struggle to understand how 'GP care without fees' is actually free if people with PHI are asked to pay for it, even if it is rolled into existing schedules of care.

Furthermore, we have considerable concerns about the implications of this move on more strategic Government documents which have at their heart, a commitment to reduce health inequalities.

REINFORCING UNEQUAL ACCESS TO PRIMARY CARE

People from the most disadvantaged areas are twice as likely to die from cancer as those from the most affluent areas. As well as dying younger, they develop multiple illnesses at a younger age. In September 2014, a new map of cancer death rates was published by NUI Maynooth and showed that there are shocking health gaps even within small areas of Dublin. The map shows that cancer death rates varied from 381 per 100,000 in Blakestown North-West to 128 per 100,000 in Castleknock South-East, which are both part of the same constituency.

Cancer death rates in Dublin during 2009 - 2011 (combined) varied from:

- 381 per 100,000 in Blakestown North-West
- 310 per 100,000 in Blanchardstown North
- 265 per 100,000 in Ballymum East
- 141 per 100,000 in Foxrock/Cabinteely SW
- 138 per 100,000 in Malahide East
- 128 per 100,000 in Castleknock South-East

The more deprived the area, the higher the risk of a person getting and dying from cancer. As well as this, often the poorest in society, have the greatest difficulties in accessing healthcare. In some deprived Dublin areas, there are not enough primary care resources – for instance in North Dublin there is one GP for every 2,500 people.

We can hypothesise that given it is already unattractive for GPs to locate in deprived areas, these communities could be further disadvantaged by becoming less commercially attractive to run a practice from if this plan to load GP cover onto PHI policies goes ahead. People who can afford private health insurance and whose economic status may mean they have fewer serious health problems than those in poor communities, will increase the frequency they see their GP (caused by moral hazard) but won't have the comorbidities of disadvantaged groups. This will lead to quicker consultations which will mean doctors can see more patients and therefore earn more.

While increased demand on GP services in wealthier areas could lead to reduced supply, resulting in lower quality of care and may contribute to long waiting lists, the Irish Cancer Society believes that the attraction of shorter and therefore more lucrative consultations could result in a flight of GP practices from poorer communities to better-off neighbourhoods to meet increased demand.

The Irish Cancer Society has never supported a system that distinguishes between patients based on their ability to pay, but there is a real danger that including GP cover on PHI policies could actually entrench an unfair system and create a geographical and health-status divide between patients. We have major concerns that GPs may prefer to treat patients covered by private health insurance than those who have medical cards or are without any cover at all.

INTEGRATED CARE MODEL

The Adelaide Health Foundation recently published 'Integrated Healthcare in Ireland – a critical analysis and a way forward' which highlighted that 'integrated health systems are widely considered to provide superior performance in terms of quality and safety as a result of effective communication and standardised protocols'.

The Irish Cancer Society supports the ethos embodied in the Adelaide Health Foundation's document regarding the pursuance of a system that is fair and equitable. The authors say that the highly fragmented nature of primary care in Ireland, 'provides no base for integrated service development or a focus on the needs of populations'.

Under true Universal Health Insurance, access to treatment and care is determined by clinical need and not ability to pay. Despite the Government pursuing a much-maligned and strongly regulated system of compulsory private for-profit insurance with payments related to ability to pay and not to age, gender or health status, there is still room to ensure the provision of access to care is made on the basis of need and the payment of insurance is made on the basis of ability to pay.

Yet the hypothesis on which this consultation is based is reliant on maintaining a distinction between patients with PHI and everyone else. We are concerned that the consultation is simply a response to the unknown, but very considerable costs associated with the Government's commitment to deliver free GP care and UHI generally.

CAPACITY AT PRIMARY CARE LEVEL

The readiness of the primary care services is an essential prerequisite for the introduction of the UHI system. A new GP contract is currently being prepared and will include compulsory cooperation with the new primary care teams. The Government is planning to recruit in primary care in advance, so that allocation of posts will be governed by a consistent transparent method to supply staff where there is most need and in the most deprived areas.

If Government provides additional staffing resources, features of supply induced demand may emerge. Many Trusts in England began to offer consultants 'extra-contractual payments' (commonly known as waiting list initiatives) to clear backlogs caused by increased demand. This ended up as a huge commissioner overspend which our health economy cannot afford. If the Government is unable to meet excess demand through this measure, then it can deal with moral hazard through waiting times and other non-price rationing which is clearly undesirable. Therefore, although there is no easy solution, we can conclude that increasing demand at the top end of the socio-economic spectrum is both socially undesirable and economically unworkable.

The Adelaide Health Foundation says, ‘what is needed to improve the readiness of primary care to deliver effective community led services, is greater investment in primary care.’ The Department’s brief appears to be looking for answers of how private health insurers can fund its vision for primary care, but perversely, at the expense of equity in the health system.

OTHER CONTRIBUTORS TO EXCESS DEMAND

Excess demand will not only be caused by moral hazard but by changes in our demography and lifestyle factors. For instance, our aging population, increase in chronic diseases and increases in cancer rates will put additional pressure on already struggling health services.

One in three people in Ireland will develop cancer during their lifetime. In Ireland an average of 30,000 new cases of cancer are diagnosed each year. The number is expected to rise to over 43,000 per year by 2020. This is compared to 29,775 people being diagnosed with cancer in 2009, 15,364 men and 14,441 women.

If we are serious about moving from acute to primary care, GPs will need to be working on disease prevention strategies for their patients alongside treating diseases. The Irish Cancer Society has heard that GPs are so overworked, particularly in disadvantaged areas where comorbidities are common, that they simply don’t have time to talk to their patients about how to reduce their chances of getting cancer (like quitting smoking) because there are more ‘serious’ health problems that need to be addressed.

This issue is not just specific to cancer but to all chronic diseases which are increasing across the population but especially in low-income groups.

SUPPLY INDUCED DEMAND

If the approach discussed in the Department of Health's brief on this issue were to be pursued, the Irish Cancer Society considers supply induced demand and FFS to be potential issues because of the third-party payer phenomena.

Supply induced demand can emerge when the way in which providers are reimbursed may influence the incentive to increase supply. A fee-for-service (FFS) system, in which providers are reimbursed for each procedure they carry out, is likely to encourage greater utilisation. A capitation system, in which providers receive a fixed payment for each patient under their care, is less likely to encourage it. There is no explanation in the Department's brief as to what reimbursement method would be used.

If the health care system has excess demand, say, because of a cash limited public health care budget leading to waiting lists, then there is unlikely to be an incentive to induce additional demand. Whereas, if there is excess supply in the market, the incentive for induced demand may exist. The Government has said it will meet excess demand with increased supply, creating the potential for SID to exist.

In systems with third party payers, there may be less incentive for patients to control utilisation, whereas in systems that rely on out-of-pocket payments, there may be more incentive.

MOVE FROM ACUTE TO PRIMARY CARE SETTINGS

The Irish Cancer Society would welcome a shift to primary care from hospital settings for cancer patients. Hospitals can be distressing, particularly if the care can be provided by a local GP. However, GPs would need additional training and education to deal with diagnosis, treatment and survival issues of those patients who have cancer.

Clinical pathways would need to be developed and published for all cancers so that there was clear clinical protocol for GPs. We urge further and separate consultation with the Irish Cancer Society if there is an impetus to move more cancer care into community settings. We do not feel that the brief we are responding to gives adequate scope to reflect on this issue in any detail.

PALLIATIVE CARE

In end of life care a value-based purchasing system must be based on a best practice pathway incorporating a multidisciplinary approach to care. This includes medical and nursing palliative care specialists, social worker, psychologist, pastoral care, physiotherapy and occupational therapy.

A 1997 IOM report suggests that physicians may be encouraged to limit time spent with dying patients because the payment system does not recognise the resources, (such as a longer evaluation and management time and interdisciplinary teams), needed to provide high quality palliative care.

In treating palliative patients, a best practice pathway is essential at the onset of care delivery as time may be short for many of these patients and setting prices by reference to average costs may have negative outcomes in terms of complex symptom management and psychological care. In treating complex pain, administration of an epidural block may be necessary, which is a more costly

procedure than mainstream pain management protocols. It is recommended this should have a separate funding stream.

The benefits to the hospital is highlighted by Imhof and Kaskie (2005) in a study of four hospital-based best practices end of life care programs which found that the provision of evidence-based end of life care can decrease service costs by increasing staff efficiency, and reducing the consumption of expensive service interventions.

There is a concern that the outlier policy may encourage hospitals to discharge older, dying patients quickly without proper discharge planning and move them to a setting which lacks the resources needed to provide quality end of life care.

Timely access to specialist palliative care in primary care may not be possible following a rapid discharge. A right to a dignified death is inherent within the Irish Constitution and lack of access to specialist palliative care may deny the patient this right.

Lack of resources in the community may also increase readmissions to hospital because of symptom management problems. An integrated discharge plan from tertiary care back to primary care with an appropriate funding model is required to mitigate against these problems.

Overall the Department of Health's efforts to shift care into the community setting is an opportunity to end the current regional inequity in hospice services and variations in palliative care provision. If palliative care was effectively integrated into primary care services, it could provide:

- Equal access to services for patients.
- The patient can be cared for in their own community at the appropriate lowest level of complexity.
- Local GPs lead primary care teams coordinating integrated patient care.

In supporting end of life care for cancer patients in the primary care setting, the Irish Cancer Society provides a night nursing service in the patient's own home.

In 2012 the Irish Cancer Society provided 7,350 nights of care to 1,818 cancer patients. The average cost per night of care is €350, this includes all costs related to salaries (with the exception of pension payments) training and recruitment costs, administration and lighting and heating.

We urge the Department of Health to engage in dialogue with the Irish Cancer Society, outside of this consultation, on how we can work together to advance our shared agenda around the provision of palliative night nursing services at community level.

CONCLUSION

The Irish Cancer Society strongly supports efforts to move care from hospital to primary based settings. We feel that particularly in the case of cancer, which is a disease that more and more people are surviving, that there are significant opportunities to enhance people's quality of life by providing appropriate care in an appropriate setting.

However, our backing of the proposals contained in the Department of Health's briefing document, stops there.

Not only do we feel that the consultation gives limited and inadequate consideration of the enormous task of moving services into community settings, it proposes a funding mechanism for 'GP care without fees' that would entrench health inequalities. Given the commitment by Government in recent policy documents to try and eradicate a two-tier health system, we are hugely disappointed to see this approach even being considered.

It is also unclear as to how the funding approach of 'GP care without fees' relates to the Government's ambition to deliver UHI. We feel that including free GP care on private health insurance policies is evidence that maintaining the status quo and allowing our society to exhibit stark health inequalities between the rich and poor, is all we can expect for from our health service.

The Irish Cancer Society believes that the people of Ireland deserve more than this.

We hope that some of the issues we have highlighted in our response will be considered so that a more equal and caring health service can be achieved.

ENDS.

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