An Economic Analysis of Public Versus Private
Provision of Health Services in Ireland

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Abstract

Governments everywhere are under pressure to deliver service to the community in a situation where the expectation of the population is growing and the public finances are static or falling. To address this problem many regimes seek to increase their financial base by encouraging the private sector to become involved in areas of service delivery which had previously been the preserve of the public sector. The advent of the Private Finance Initiative in the United Kingdom in the early 1990s, which morphed into the Public Private Partnership, was one method of selling to the public the idea of private involvement in public service delivery. Many believed this was a positive development. Others thought this was the private sector putting its hand into the public purse with no other motive than to enrich itself. This thesis asks: Does it matter who owns the means of delivery? The most efficient method of delivery is surely the one which costs the taxpayer the least and conveys the best product to the public in terms of quality. Delivery of health services is not simple. Indeed to speak of a ‘health service’ as one homogeneous product is to misunderstand the nature of the service. It is a range of services delivered to a range of people in a range of different settings, some of which are appropriate and some of which are not. Each individual service to each individual patient is a unique transaction. Countries such as the United Kingdom, Sweden and New Zealand have all made efforts to dramatically change the public service delivery of health care. Most have found changes to be problematic and some have returned to the public service model. In this thesis we test the issue of ownership in cases where the comparison can be made and look at the occasions where attempts were made to introduce the private sector into the public delivery of health, and assess whether or not the experiments were for the good or to the detriment of the stakeholders in the Irish context. We look first at the international situation to put the subject in context. Then we lay out our theoretical framework. We contemplate the infusion of private sector involvement in public service delivery. This is followed by our cases of comparison between the public and private sectors. Today Ireland’s spending on health as a percentage of Gross Domestic Product is such that we could expect a world class service. Our findings suggest that a cautious approach should be taken by policy makers but the expectation of the public and the diminishing nature of public finances means that innovative, tailored and sector specific solutions to the many difficulties in the services will need to be crafted. This thesis is a unique examination of the public and private delivery of health care in Ireland and contributes the first analysis of the current situation.
Declaration

The work presented in this thesis is the sole work of the author except where duly acknowledged and referenced. It has not been submitted to any other university or higher education institution or for any other academic award.

____________________________

Gerald O’Nolan
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<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<tr>
<td>AAOS</td>
<td>American Academy of Orthopaedic Surgeons</td>
</tr>
<tr>
<td>AT&amp;T</td>
<td>American Telephone and Telegraph Company</td>
</tr>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
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<tr>
<td>BMG</td>
<td>Beacon Medical Group</td>
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<tr>
<td>C&amp;AG</td>
<td>Comptroller and Auditor General</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<tr>
<td>CSO</td>
<td>Central Statistics Office</td>
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<tr>
<td>DBFO</td>
<td>Design, build, finance and operated</td>
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<tr>
<td>DRG</td>
<td>Diagnosis Related Groups</td>
</tr>
<tr>
<td>DHSS</td>
<td>Department of Health and Social Security (British)</td>
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<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>DOHC</td>
<td>Department of Health and Children</td>
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<tr>
<td>EEC</td>
<td>European Economic Community</td>
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<td>ESRI</td>
<td>Economic and Social Research Institute</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>GNP</td>
<td>Gross National Product</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>HCP</td>
<td>Hospital Co-location Project</td>
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<td>HIPE</td>
<td>Hospital In-Patient Enquiry Scheme</td>
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<td>HIQA</td>
<td>Health Information and Quality Authority</td>
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<td>HSE</td>
<td>Health Service Executive</td>
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<td>ICT</td>
<td>Information and Communication Technology</td>
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<td>IHCA</td>
<td>Irish Hospital Consultant’s Association</td>
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<td>IITOS</td>
<td>Irish Institute of Trauma and Orthopaedic Surgery</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<td>IMO</td>
<td>Irish Medical Organisation</td>
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<td>LOS</td>
<td>Length of Stay</td>
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<td>MBR</td>
<td>Market-Based Reform</td>
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<td>MSICS</td>
<td>Manual Small Incision Cataract Surgery</td>
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<td>NDFA</td>
<td>National Development Finance Agency</td>
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<td>NHS</td>
<td>National Health Service (British)</td>
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<td>NIE</td>
<td>New Institutional Economics</td>
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<td>New Public Management</td>
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<td>National Roads Authority</td>
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<td>National Treasury Management Agency</td>
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<td>NTPF</td>
<td>National Treatment Purchase Fund</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>PbR</td>
<td>Payments by Results</td>
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<td>PCG</td>
<td>Primary Care Groups</td>
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<td>PCT</td>
<td>Primary Care Trusts</td>
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<td>PFI</td>
<td>Private Finance Initiative</td>
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<td>PHI</td>
<td>Private Health Insurance</td>
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<td>PPP</td>
<td>Public-Private Partnership</td>
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<td>PTR</td>
<td>Patient Treatment Register</td>
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<td>SBC</td>
<td>Soft Budget Constraint</td>
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<td>SDU</td>
<td>Special Delivery Unit</td>
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<td>SOE</td>
<td>State Owned Enterprises</td>
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<td>TCE</td>
<td>Transaction Cost Economy</td>
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<tr>
<td>UCD</td>
<td>University College Dublin</td>
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<tr>
<td>VHI</td>
<td>Voluntary Health Insurance</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WLI</td>
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Introduction

The cost of delivering public services has become a challenge to governments around the world. This is particularly true of health care and some suggest private business interests are more appropriate agents to deliver these services than government or municipal authorities.

Medical inflation has continued to outstrip general prices in economies since it was first measured in the 1940s and shows no sign of slowing down. Advances in technology and western society’s wish to use the best and latest developments in medical and surgical techniques – and its seeming willingness to pay for it – means the funding model of health service delivery needs to be re-engineered.

The emergence of New Public Management as a philosophy in the 1980s and the example of the United Kingdom influenced many governments to attempt to infuse a private business ethos into public service delivery. Private involvement in public works was nothing new (Wettenhall 2006, Hodge and Greve 2007). Post-Second World War, particularly in Europe; delivery of public services to the citizens was seen as the job of local or national government. Nothing epitomized this as much as the National Health Service (NHS) in Britain. By the 1990s all of this was becoming unaffordable. Countries like Britain, Sweden and New Zealand, who prided themselves on being pioneers of universal health care to the community, regardless of ability to pay, now began to try market-based reforms and the semi-privatization of their health services. The private, for-profit delivery of public services paid for by the public purse had now become commonplace. In Ireland private health care has mushroomed in recent years, helped and encouraged by government (Burke 2009) so today mixed delivery of health services is a reality.

Four principal questions arise in the context of the Irish health system: First, what is the difference between public and private provision regarding performance and behaviour in the Irish Health Services Sector? Second, what factors explain how attempts at mixed service delivery are implemented in the sector? Third, what lessons can be taken away from the experiences of other countries, that could help guide the Irish health service to a more efficient and equitable outcome? Fourth, does
it matter who owns or manages the facilities as long as the public get the services they believe that they are entitled to expect? This thesis is the first attempt to answer these questions in the Irish context.

**Historical background to the research**

In Ireland, public-private partnerships for the procurement of roads, water services, school buildings and waste management has been achieved with a relative degree of success recently, but attempts to introduce market-based reforms to the health services have been less successful. The reasons for this will be outlined in Chapter 3, but the private sector is alive and well in the Irish health service and there we ask: is the provision of health services affected by the type of ownership?

Studies in the United Kingdom, the United States and Scandinavia have thrown up mixed answers to the question of ownership, and the position is quite diverse within the many sub-disciplines of the health sector (Duggan 2000, Harrison and Calltorp 2000, Glasgow 2009, Cooper et al. 2010, Propper et al. 2004). Other writers suggest that variation in ownership effects can be explained by a study's research focus and methodology (Shen et al. 2007).

The public and private provision of health care or ‘mixed delivery’ has operated side by side for hundreds of years in Ireland, dating at least back to the Elizabethan era. In previous centuries government did not see the provision of health as something which it had any duty or business being involved with. But largely in an attempt to address social instability and horrendous poverty in Ireland (and indeed, England, Scotland and Wales) various laws were enacted from the late Eighteenth Century up to the Irish Poor Law of 1838. The Irish Medical Charities Act of 1851 finally coordinated a patch-work of medical dispensaries and hospitals which had grown up around the country and whose activities were financed by a combination of subscriptions and grants from both local and national government (Cassell 1997). The advent of the famine in the 1840s and the deaths of millions accelerated the need for public involvement in health care provision. At that time private provision of many services was considered to be the natural order of things with charitable contribution by upright well-to-do Christians and the system was ‘topped up’ with support from the government. Even then the medical profession was in a battle to
improve its status and ensure that earnings were protected. In the nineteenth century
the social status and income of Irish doctors ranked below most of the professions of
the day including the church, the law, the military and the civil service (Barrington
1987, p.17). The gradual improvement in doctors’ social status cannot be
unconnected with the improvement in income but also owes something to the
advances in medical science which brought the profession greater public respect.

Theoretical Frameworks and Themes

The question of ownership is central to this study. Ownership cannot be examined
without an understanding of property rights. The establishment of those rights over
the centuries, particularly in common law countries, informs the state of property
rights in Ireland today. The exercising of, the vindication of, and the monitoring of
those rights comes with a cost. All transactions incur costs. The development of
hierarchical institutions is attributed to the attempt to minimize these costs. In some
instances a hierarchical organization will find it may be less expensive to contract
out part of its process to a specialist. Whichever choices are made they will most
likely be taken in the light of which path reduces transaction costs.

Privatization and competition of the market place have been applied to the delivery
of public services. Health services continue to defy most regularly accepted
economic rules. As mentioned above, health care is not a single discipline but a
multifaceted set of intertwining fields of specialists and sub-specialists, and what
works in one sub-discipline may not work in another. The collectivization of health
care in most developed countries is a testament to a civilized view that access should
primarily be on the basis of need. Developed societies consider the delivery of these
services as essential. Increasing the influence of the market in the delivery of these
services may have an adverse effect on the question of equity (which is far from
perfect in any case).

This thesis is focused on the mixed delivery of health care services in Ireland. Many
institutions involved in health care delivery fall into three categories: private,
voluntary, or public. Public institutions are owned and funded by the state from
taxation. Private institutions receive no funds from the state and are run as a business
by individuals who are looking for a return. Voluntary public hospitals are sometimes owned privately by religious orders or minority groups. Other voluntary public hospitals are incorporated by charter or statute and are run by boards often appointed by the Minister for Health. (This is mostly for historical reasons where a tradition or ethos is being preserved but for all practical purposes voluntary hospitals, in particular, are under the control of the state.)

When examining an entity as large and diverse as the health service of any country a number of themes will emerge. These include: public choice, property rights, opportunism, asset specificity and path dependency among others, but most importantly there is the issue of transaction costs. With these economic perspectives at our disposal we undertake an analysis of the different delivery structures for health services in Ireland.

**Research Motivation**

There has always been a significant private element to health care delivery. Indeed as has already been stated, state involvement emerged slowly over the centuries, often as the unintended consequence of other policies. Private sector delivery has been favoured by some clinicians and patients over time for a variety of economic and cultural reasons (Watson and Williams 2001). In an attempt to compare the performance of the two sectors, examining the cases of hip replacements and cataract extractions provides us with a relevant platform to make comparisons between public and private health care delivery. The nursing home industry also provides an example of the relative performances of both sectors with the availability of measurable data.

Some attempts to increase private elements in the health sector have been tried but so far these have met with mixed results at best; for example: The National Treatment Purchase Fund (NTPF) which sourced private solutions for those public patients who had been on a waiting list for medical or surgical treatment. This was a successful project to the extent that it carried out its mission as instructed, but detractors of the
NTPF suggest that it was very expensive and created a number of perverse incentives (interviews with surgeons and hospital CEOs).

Another example is the public-private partnership (PPP) for the National Plan for Radiation Oncology (NPRO). This programme, encompassing seven centres, started in 2008 when the first two were completed without any problems in what has been termed as a great success. The remaining five PPP centres have not proceeded. One reason may be the lack of appetite, on behalf of the banks, for such large projects in the wake of the 2008 crisis. The perceived level of uncertainty and risk at the current time, and the return on relative bond yields has put a stop to this project for the foreseeable future.

As is discussed in Chapter 3, the attempt to establish co-located private hospitals on the grounds of public hospitals never progressed beyond the procurement stage due to multiple complex reasons which are discussed in Chapter 3. These events provide the basis, reason and motivation for the research. It is proposed to analyse this phenomenon with a focus on outcomes.

Comparing these cases with the extent and vigour with which reforms were undertaken in other countries tells us a considerable amount about the culture of governance in Ireland today and how it has been informed by its history. Like the NHS is Britain, it seems that there will be a continuous effort to involve private finance in the delivery of public services. However, before moving ahead in an isomorphic drift, analysis of what has happened and why, it will be useful for policy makers of the future. As some of the cases examined are relatively recent, no other analysis has, as yet, been carried out. This thesis addresses the issues of the attempts to introduce market-based reforms to the health service, ownership and the purchaser-provider split.
Objectives of the Research Study

Having regard to the historical context and institutional regularities in Ireland, in this thesis we chose cases where there is a direct and measurable comparison between the performance of public and private provision of health services in Ireland.

Specifically the following issues are examined:

- The case of hip replacements in public and private clinics in Ireland
- The case of cataract extractions in public and private clinics in Ireland
- The case of public and private nursing homes in Ireland
- Examine the motivation behind efforts to stimulate the private sector in the health service

These will be examined using specific methodologies appropriate to each case.

Methodological Approach

The case studies examined in this thesis demonstrate the diversity in the different areas and sub-disciplines of the health services. To examine relative performance we look at the cases of hip replacement, cataract extractions and nursing homes in the public and private sectors. As in many areas of Irish life, statistics are not readily available or easily sourced. This is striking in its contrast with the Scandinavian countries where large amounts of data on public services, and on health matters in particular, are available to anyone with an internet connection. We met with some difficulty even requesting specific information collected by the Economic and Social Research Institute (ESRI), and requests to access documents from the Health Service Executive (HSE).

Confidentiality, ethical considerations and commercial sensitivity were all cited as reasons for not giving the type of information readily available in other countries. Despite the unavailability of data (and the reluctance to make available what was there), we used a mixture of qualitative and quantitative methods to get the maximum possible amount of information on each topic.
A total of 33 interviews were carried out with consultant surgeons, general practitioners, pharmacists, politicians, hospital CEOs, health care business people, legal advisors and civil and public servants. Most were carried out ‘in person’ at the workplace of the interviewee. A small number were done over the phone. The interviews were transcribed by the author and amounted to over 150,000 words of text which were then subjected to textual analysis using the software ‘N Vivo’ and evaluated for credibility and validation. The gathering of this data represents one of the contributions of this thesis.

A certain amount of data is publically available and where it was not available we conducted our own survey. In the case of nursing homes a large amount of information is now in the public domain. It was possible to produce (by hand) a comprehensive database of information on costs, population, the qualification and level of staffing and the number of deficiencies counted on each inspection. This type of data is suitable for full statistical analysis, and we conduct this analysis in Chapter 4. The approach and methods employed reflect our judgement of the best chance of elucidating the details and characteristics in each case, which in some instances describe happenings of the very recent past which were otherwise unrecorded and which were unlikely ever to be aired in public.

The objective of this research is to examine the operation of the public and private sides of the Irish Health Service. In this thesis we examine attempts to energize the private sector so that it would supplant the role of the public sector in two areas: Hospitals Co-location Project (HCP) and the National Treatment Purchase Fund (NTPF). We also examine performance between the public and private sectors in the cases of hip replacements, cataract extractions and nursing homes.

The chapter on mixed delivery in health services seeks to make a comparison between two other areas where the private sector sought to become involved in services which had been purely publically delivered. The HCP failed to reach the procurement stage and the NTPF, while nominally successful, is no longer an agency exclusively involved in the direction of public patients into the private sector.

Similarly to other chapters a lot of the facts surrounding the HCP have been undocumented by reason of ‘commercial sensitivity’ while the process proceeded and by the potential of law suits since it was abandoned. Interviews were targeted at
all the key people who were involved in these processes on both the public and the private side and a story emerges of the complexity of the health section when any, even minor, reforms are contemplated.

For our examination of the nursing home sector we have gathered together a database of all 612 registered nursing homes in the country. The information is derived from the inspection reports of each individual home. Detailed inspections have been carried out by The Health Information and Quality Authority (HIQA) since August 2009. Some homes have been inspected once, others up to seven times. We have included the information from up to five inspections over the period up to the spring of 2012 using statistical analysis to make comparisons between three types of ownership: public, private and voluntary.

The chapters on both hip replacements and cataract extractions use data collection and analysis using techniques previously validated in similar studies in other countries (Andersen and Jakobsen 2010). Qualitative data on hip and cataract extractions has been gathered by way of interview with health professionals and facility managers. Quantitative data on hip replacements and cataract extractions is sourced from public registers such as the Health Information and Quality Authority (HIQA), the National Patient Treatment Register, Hospital In-Patient Enquiry Scheme (HIPE), individual hospital ‘Patient Satisfaction’ surveys and Casemix Ireland who monitor activity and costs of hospitals.

In using the qualitative technique of in-depth or semi-structured interviews the author recognizes that unexpected themes emerge from the data. An inductive approach has been taken to the gathering of data. Bryman and Bell (2007) suggest that in qualitative research, theory is something that emerges out of the gathering and examination of the data rather than the specific testing of theories that are detailed at the outset.
Structure of the Thesis

Chapter 1

Chapter 1 provides an international perspective on public and private provision of health care. It sets the context for examining ownership within health care delivery. We study four countries: United Kingdom (UK), Sweden, Australia and New Zealand. In recent decades the UK was the primary force in the move towards market-based reforms. The UK example was followed by the other three countries. The experiment was largely abandoned and reversed in Sweden and New Zealand but continues in the UK. In Australia the system was not as advanced in delivering medical services free at the point of delivery. They have continued to involve the private sector.

The conceptual map lays the framework of the study. A version of this map with the relevant parts highlighted will be displayed at the start of each chapter to guide the reader through the argument of the thesis.

The conceptual map starts with viewing mixed delivery in health through reforms in other countries and then makes the comparison to the Irish situation. The theories which are examined in Chapter 2 are applied to two distinctive branches of our study. The right hand side contains the three cases where we examine performance through the case studies of hip replacements, cataract extractions and nursing homes. On the left hand side we have the cases of agents of change whereby attempts were made to give the private sector a greater share of control in the health care sector.

The red arrows represent the connections from the international experience through the Irish situation, all connecting with the relevant theoretical frame, and arriving at conclusions. The green arrows reflect the influence which international experience has on informing the changes in the local institutions, again arriving at the conclusions and reflections.
Legend:
Blue/transparent boxes (through the middle) represent context, theory and conclusion
Tan/transparent boxes (to the left) represent agents of change/attempted change
Purple/transparent boxes (to the right) represent cases of performance
Red arrows connect the questions with theory and the cases
Green arrows connect the international with our cases and then to the conclusions
Chapter 2

In Chapter 2 we examine the theoretical underpinning which informs our analysis of the actual case studies. The economic framework used in this thesis needs to be divided into two sections. First, we look at two cases where the government sought to put the private sector into areas previously occupied only by public delivery of service: the Hospital Co-location Project and the National Treatment Purchase Fund – engaging the private sector. Then we examine the relative performance of the public and private sectors in the cases of hip replacements, cataract extractions and nursing homes.

For the examination of performance we look at health as a public good and discuss public choice and property rights. An examination and analysis of institutions and rules in Chapter 2 is followed by a questioning of the historical path dependency which has had a bearing on the state of our modern institutions. These institutions and the laws that govern them are a result of one thousand years of the development of property rights under common law. One of the central themes of this thesis is the issue of ownership. New Institutional Economics (NIE) is concerned with transaction costs. NIE claims the business route which produces the least transaction costs determines the profile of the institution, that is, whether specific parts of the production are carried out ‘in-house’ in a hierarchically controlled organization or whether it is contracted out. This is the old ‘make or buy’ question. This chapter then considers the issues of privatization and competition. In looking at markets and hierarchies we look specifically at markets in health and the issue of asset specificity.

In considering the issue of the provision of service through engaging the private sector we look further at institutions and ask: what causes institutions to change? Using Saleth and Dinar’s (2004) Three Layer Schema which is a synthesis of a similar schema by Williamson (1993) with elements from Eggertsson (1996) we examine the forces, in the Irish context, which accelerate or prevent change and the use of power and the resulting winners and losers. We find in the Irish context the influence of private sector operators was much less than the public sector administration, and this goes quite some way to explaining the failure to launch of these PPP initiatives.
Chapter 3

This chapter considers the issues surrounding the attempt to bring market forces in the shape of private operators into parts of the health system. The Hospital Co-location project fits with a growing trend of using Public Private Partnerships in Ireland. The proposal to locate private hospitals on the campus of existing public hospitals was an idea which gained ground in Australia (Brown and Barnett 2004). The evidence in this case was characterized by a strong degree of dissonance between parties especially on the public sector side of the transaction. The failure to complete procurement in the case of hospital co-location was also attributable to relatively high transaction costs due to uncertainty, fear of opportunistic behaviour, a failure to agree an appropriate model of risk-sharing and a poorly worked out business plan (interviews with business principals involved). Much of the detail we present on this subject never appeared in the public domain and was gathered through interviews with many of the key people who were directly involved in the project. The second part of the chapter is an examination of the National Treatment Purchase Fund and how it was designed to resolve the waiting lists which had been building up for access to medical and surgical services for public patients. We find although the NTPF did its job in an efficient manner it was costly and created many perverse incentives within the public-private mix.

Chapter 4

This chapter is a statistical study of the comparative performance of public and private nursing homes. There are a total of 612 registered nursing homes in Ireland falling into three ownership categories: public, voluntary and private. Since 2009 regular inspections of all nursing homes are carried out by the Health Information and Quality Authority (HIQA). A report of these inspections and details of the number of residents, the number and category of care staff, the number of deficiencies at each visit and when the facility was established, is publically available. Also available from the Health Service Executive (HSE) are the weekly charges applied to each resident. We created a database of all the nursing homes in the country including data from up to five inspections per home. Using this database we test the hypotheses: are public nursing homes associated with lower deficiency (a
proxy of higher quality of care) and is price negatively related to level of deficiency and staffing? We find public nursing homes are associated with higher cost, lower responsiveness to actionable items and lower flexibility relative to private nursing homes.

Chapter 5

Chapter 5 is an in-depth study of the provision of hip replacements in Ireland. We compare the same operation performed in public and private facilities. We wished to discern any differences in professional behaviour, treatment quality and patient satisfaction. Surgeons and professional managers were interviewed for their views on these issues, looking for differences between the public and the private sector. This investigation was prompted by a similar one carried out in Denmark. Hip replacements as a procedure were chosen because it controls for the wide variety of the intake of patients and their diagnosis. We examine incentives and motivation within the profession of consultant surgeons and analyse the environment of the health service in which they work. We find ownership, per se, was not an issue for the provision of these services, and any difference between public and private services was neutralized to a large extent by professional norms.

Chapter 6

Our fourth case study is an examination of the provision of cataract extractions in both the public and the private sectors in Ireland. Similar to Chapter 5’s subject on hip replacements, cataract extractions operations are elective and are carried out in both public hospitals and private clinics. We look in detail at this sub-speciality and examine the incentives and motivation of the professionals involved. Not surprisingly many of the characteristics of orthopaedic surgeons are repeated with the ophthalmic surgeons but there are some variations as to how the profession is organized and how incentives work. We find professional norms dominate any public or private division.
Chapter 7

The final chapter provides a summary discussion of the research presented in the thesis. We re-inspect the research rationale, the methodology and review the core findings and the contribution to the knowledge. We acknowledge the research limitations and discuss potential implications for public policy. Before concluding we suggest some fruitful areas of future research.
Chapter 1:

Mixed Delivery in Health

1.1 International Experience

Since the 1980s many governments changed their approach to the delivery of health services from the post-World War Two predominance of the public system to experiments with greater involvement of the private sector. The United Kingdom, in particular, influenced many countries to take this path. With cultural ties and common language and history it is the UK reforms in their successes and failures which may be most instructive in the Irish context. Closely following the UK experience, Sweden introduced similar changes to its health system. Other countries from whom we could draw lessons and with whom we have cultural ties are Australia and New Zealand where a number of Market-Based Reforms (MBRs) were also tried. New Zealand in particular, with a similar population to Ireland, pursued market-orientated methods aggressively in the 1990s but has reversed the reforms and returned to the way things were in the 1980s.

1.2 Introduction

The purpose of this chapter is to examine the international experience of mixed ownership models and substantial reforms in health services, some of which were successful and some of which were abandoned. The international experience provides a context for the principal issues examined in this thesis which focus on similar mixed models of delivery in the Irish system. While many countries have had experience in introducing MBRs into their health care systems, we shall examine the practice in the United Kingdom, Sweden, Australia and New Zealand.

The United Kingdom is the most important of these having been the first country to implement changes and has gone further than most. Ireland’s public health system was conceived while the country was part of the United Kingdom and so the shared culture in many institutions allows us to visualize similar reforms in the Irish context. Australia and New Zealand share Ireland’s colonial past and the emergence
of self-government in the three countries was informed by the development of ideas similar to all.

Figure 1.1: *Conceptual Map Chapter 1*

Legend:
Blue/transparent boxes (through the middle) represent context, theory and conclusion
This chapter examines international examples of reforms in health to put the Irish developments in context
Sweden has a culture which developed in a different way to the other countries being examined. It is a state which has been economically and socially successful and represented an ideal society for many observers in other countries. In the 1990s, soaring public spending put the welfare state as a concept in need of repair and it was, to Britain that Sweden looked for inspiration when reforms were needed. In Sweden we can see the anatomy of the attempted dismantling of the health system and the subsequent rejection of many of the reforms.

Each state’s health system has developed over a long period with the resultant institutions reflective of the culture, history and economy of that country. No two are precisely alike. Changes, for better or for worse, have often been forced by economic upheaval, war, religious conviction, ideology and fashion (North 1991, Galbraith 1958, Saleth and Dinar 2004). Indeed it is possible only fashion in ideas, or possibly institutional isomorphism\(^1\), drove the MBRs of the last thirty years. While the ideological and theoretical frameworks are ever-present to make arguments from the perspective of the left or the right it is clear many reforms and their subsequent curtailment or discontinuation were implemented by governments of many hues and very often for purely practical reasons. Societies, particularly in Britain and in Sweden, were proud of their universal health care and even the most conservative sections of those societies were reluctant to see welfare traditions irreversibly dismantled. Equally with the return to power of left wing governments many of the cultural effects of the MBR experiments were left in place. This chapter will explore in detail the history and the development of reforms in these four countries with a view to establishing the initial aims of the MBRs and whether, in fact, they delivered on their expectations of greater efficiencies and more responsiveness to the needs of the consumer.

1.3 New Public Management

In order to contextualize the atmosphere into which the notion of MBRs and quasi-markets in the health services gained recognition it is necessary to look at the bigger shift in thinking about new ways to govern the management of public services. New Public Management (NPM) became the name of a philosophy used to modernize the public sector with competition and incentives and was gradually adopted by governments in the 1980s (Hood 1991). The main thrust of NPM as a philosophy was the introduction of market-oriented initiatives into public organizations would lead to greater cost efficiency and consumer responsiveness, while maintaining the values and access to public services. Hood (1991, p5) suggests that it has its origin in ‘a marriage of two different streams of ideas’. The first idea being ‘New Institutional Economics’ with emphasis on public choice, transaction cost theory and principal-agent theory. The second idea was the latest wave of business type ‘managerialism’ in the public sector. The notion is management expertise is transferable from private sector to public sector and managers must be free to manage. (That is, to manage in the style of demonstratively successful organizations in the private sector (Ferlie et al. 1996)). It must be emphasized that this was not a purely British phenomenon but an international trend noticeable in many OECD countries from the late 1970s onward (Hood 1991). It is into this background that we examine market oriented changes in health administration in four countries.

1.4 United Kingdom

1.4.1 Quasi-market reforms in the British NHS
The National Health Service commenced on 5th July 1948. Despite huge public support it was not without its detractors. The Second World War had just finished and there was a shortage of nurses, equipment and suitable buildings (Bevan 1948). Many doctors believed their incomes would suffer. Despite these reservations, the NHS became an object of pride for many Britons and operated, with a largely unchanged structure and funding, until the reforms of the 1980s and 90s.
From the end of the Second World War to the early 1970s saw the most sustained period of growth in Western Europe and the United States (Eichengreen 2008). Whilst the NHS was held in affection by the majority of British people some conservative observers continued to oppose the concept of the Welfare State. In the post war years and particularly from the early 1960s onwards, serious proposals for voucher-based systems in education and insurance-based solutions for health had been put forward (Greenaway 1991). When the Conservative party under Mrs. Thatcher came to power in 1979 it was not surprising that a close look would be taken at the workings of the NHS. The oil shock of the early 1970’s had plunged the west into recession and had accentuated the ideological divide in Britain where a struggle ensued between the Trade Unions and the Conservative Government led by Ted Heath. By 1979 many had made up their minds that Government had grown too big and greater efficiencies would be found with the involvement of the private sector. Surprisingly, the first two administrations led by Mrs. Thatcher did not make a frontal attack on the Welfare State, with the exception of the sell-off of council houses (Le Grand 1991). However the beginnings of a transition to the market-based reforms started in the health service with the introduction of ‘general management’ and the outsourcing of non-clinical hospital services such as cleaning, catering and laundry. General Management was a new layer of professionally trained hospital managers whose position was between the civil servants and the health professionals (Talbot-Smith and Pollock 2006). Outsourcing services was the first involvement of the private sector within the NHS.

Fotaki (2007) asserts NHS reforms were motivated purely by ideological argument (Fotaki 2007). Blendon and Donelan (1989) argue much of the debate on the subject of privatization was driven by ideology, with very little evidence to support the proposition that improvements would flow from reform. The NHS held a different position to the other plans of Tory reform in the 1980s. Early suggestions the NHS would be subjected to the privatization subsequently carried out at companies such as British Gas or Sealink were met with such universal opposition Mrs. Thatcher was forced to pledge: “the NHS is safe with us” at the 1981 Conservative party conference (Timmins 1995). Timmins (1995) writes that, for the Prime Minister,

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2 British Gas and Sealink were both state owned enterprises which were sold to the private sector by the Conservative Government between 1984 and 1986.
tinkering with such a sensitive institution was a fourth term project and not a third term one. The birth of quasi-markets and the other reforms in health heralded by the 1989 White Paper appeared to have come about more by a series of accidents than by design.

During the 1980’s health authorities had balanced their books by closing hospital beds and delaying paying their bills towards the end of each year. A very similar pattern of behaviour has been a part of the HSE management of the Irish health service in recent times (Cullen 2012). The United Kingdom’s spending on health between 1981 and 1990, expressed as a percentage of Gross Domestic Product (GDP), remained fairly steady at 5.9 to 6 per cent (OECD 2008). However, innovation and medical inflation meant that more funds were needed to keep the NHS at the levels of quality it had been at in previous decades (BBC News 2002). France and Germany increased health spending in that decade (OECD 2008) but the British NHS was forced to budget with less resources and greater demand. By 1987 the level of debt in the NHS was rising and to bring matters to a head the Minister with responsibility for the service, Norman Fowler, instructed the health authorities not to close any beds that year as a general election was in the offing. Mrs. Thatcher won her third term as Prime Minister in the June 1987 election but the new health minister, John Moore, faced a bankrupt NHS (Rivett 1998). Instead of demanding more money from the Treasury, Moore was forced to implement greater bed closures which led to industrial unrest by nurses and doctors (Timmins 1995). In November a cabinet sub-committee led by the Prime Minister started a review of the NHS and in January 1988, under pressure, Mrs. Thatcher announced a review was already under way. Various ideas were proposed such as opt-outs for people who could afford to pay for their own health care or tax breaks for private medicine. All were rejected. Opt-outs would reduce the revenue for the service without reducing its workload. The new idea to emerge was the structure of the service itself: the purchaser-provider split. Separating these two functions could create an internal market in health. Kenneth Clarke replaced Moore in the Department of Health and Social Security (DHSS) in July and it was Clarke who came up with the idea of General Practitioner (GP) Fund-holding. GPs would be given a budget out of which they could purchase hospital and specialist treatments for their patients. The local GP would be best placed to make the judgment on who had priority to what treatment – what Le Grand
(2003) calls: “the hard rationing choices that every health-delivery system has to make”. The GP now had an incentive to use the funds as efficiently as possible and the money would follow the patient (Rivett 1998).

A review of the NHS reported in January 1989 in the form of a White Paper entitled ‘Working for Patients’ (Department of Health (UK) 1989). Left wing observers had expected a move towards health insurance to provide extra money but the review accepted many of the basic principles of the NHS (Rivett 1998). The service would continue to be funded by taxation and would be free at the point of delivery. The changes feared by many who worked in the service never materialized. What was proposed was an improvement in productivity by effecting a change in incentives and management and the introduction of a market in the provision of health services. Increases in productivity were to be achieved by splitting the functions of providing the service from the function of purchasing it. Rivett (1998) lists the following key changes in the NHS following the 1989 White Paper:

1. Regions and districts received funds according to the size of their resident populations, weighted for age and morbidity and for the differences in the cost of providing services. RAWP\(^3\) had almost established equity so it was easier to move from historic allocations to a weighted capitation system.
2. The hierarchy of the NHS management was replaced by a 'local dynamic', devolving decisions to those closest to the people and introducing greater local diversity, competition and choice.
3. Purchasing and provision were separated. Districts became purchasers, losing their hospital management responsibilities to concentrate on the assessment of needs and commissioning the necessary services.
4. Hospitals and community services could apply for self-governing status as NHS trusts (providers).
5. GP practices with 11,000 or more patients could apply for their own NHS budgets to cover their staff costs, prescribing, outpatient care, and a defined range of hospital services, largely elective surgery.
6. Systems of medical audit were introduced to ensure quality of service.
7. Regional, district and family health services authorities were reduced in size and reformed on business lines, with executive and non-executive directors (Rivett 1998).

As soon as the proposals were published they were rejected by the British Medical Association (BMA) who insisted the whole problem with the health service was

under-funding (Rivett 1998). The legislation was passed in 1990, and would come into effect in April 1991. By 1994, when the reforms were being claimed as a great success, the health spending of the United Kingdom had risen to 7 per cent of GDP, up from 6 per cent in 1990 (OECD 2008). This supports the BMA’s claim that the service was under-funded.

Initial analysis of the problems in the NHS concluded: “there was a potentially limitless demand for health care if it was provided free at the point of delivery” (Rivett 1998). Studies in the U.S. suggest the rate of health care demand is directly related to the availability of supply: “Supply appeared to drive demand, defying most people's basic economic beliefs” (Wennberg 1996, cited in Rivett 1998, p.382) . Although Britain had fallen behind other comparable countries in health spending, the Chancellor of the Exchequer, Nigel Lawson, argued that increased spending without reform was not sustainable.

Rejection of the reforms by the BMA was based on more than funding concerns. Doctors feared a drift to a more open market system. Fund-holding would be suitable for elective procedures on patients who were in a position to exercise reasonable judgement and would ensure the money would be spent in their best interest but how would this work out for the elderly or the mentally incapacitated? Many of the finer details were not worked out in advance. The initial review carried out by the Government made little progress until the suggestion of the ‘purchaser-provider split’ This proposal originally came from a paper by Prof. Alain Enthoven, an American economist who specialized in health care in his 1985 paper ‘Reflections on the management of the National Health Service’ (Enthoven 1985).

1.4.2 GP Fund-holding
The idea behind Fund-holding, mentioned in the previous section, was that the GP would be given a budget to purchase secondary health services on behalf of patients. A patient could not be granted unlimited funds for health care. But the local doctor, who has the medical expertise and who knows the community’s health needs intimately, would be in a position to make rationing decisions based on who needs
attention as a priority. Putting GPs in charge of these decisions made delays or other difficulties with the service more acceptable to the patient. Decision making was decentralized, now a local person made the choices so there was increased flexibility in the system (Le Grand 2003). The important issue in making these changes was that the new incentives would bring about the desired efficiencies and would not reduce the quality of the service. Many GPs and their professional representatives believed that it would not succeed or be taken up in any great numbers. Individual practices had the choice of joining the system and taking control of their fate or staying outside and let others control it (Rivett 1998). One of the incentives to encourage GPs not to use excessively expensive and potentially unnecessary treatments was the fact that surpluses left at the end of the year could be spent on the practice. The surplus was supposed to be spent to benefit patients but it could be simply added to the doctor’s income. Some believed at the time of the reform that the allocation of the surplus represented an incentive to limit the availability of secondary care. The effect of incentives may vary between different people. In the event the incentives appeared to work to the benefit of the community in general (Le Grand 2003). The secondary services which could be purchased by the GPs were laboratory tests, out-patient appointments and a range of elective surgery procedures. The purchases could be made from private medical facilities as well as the NHS hospitals. Over the next few years the range of services the GP could access on behalf of their patients was greatly increased and the cooperation between GPs, the hospital trusts and health authorities brought about a changed culture and less of the traditional isolation of the GP.

The increase in health spending smoothed the way for the GPs and many innovations occurred in GP cooperative behaviour. However, Enthoven (2002) claims by 1998 there was little evidence of improved economic performance, better outcomes or end-user satisfaction. Politicians were able to claim a great success and argue ‘money follows the patient’ but in reality the providers – the hospitals – were not capable of responding to market forces. The introduction of the health reforms was staunchly opposed by the opposition Labour Party but their outright denunciation of the policy was softened after they lost the 1992 General Election. Rivett (1998) claims fund-holders got better deals for their patients and the fact that hospitals had to compete for the available business meant they were more responsive to the
purchasers. In such circumstances, argued Rivett (1998), it might be as well to accept some of the more positive aspects of the reforms. Labour claimed to have abolished the Conservative reforms when they swept into power in 1997 but in fact they strengthened the positive parts and had the advantage of having learned lessons along the way. The Purchaser-provider split was maintained. The new emphasis was to be on co-operation rather than competition (Le Grand 2003). The new units of fund-holding were called Primary Care Groups (PCGs) which evolved into Primary Care Trusts (PCTs). The PCTs cover large geographical areas and all GP practices are required to join one. Similarly to the fund-holding, PCTs are allowed to retain surpluses from their budgets but the PCTs cover many practices and so individual practices have less control over what they spend surpluses on. It must be spent on a prearranged list set out by the PCT.

The fund-holder reforms appeared to change doctors’ behaviour. Le Grand (2003) lists a number of advantages the patients of fund-holding practices enjoyed over their non-fund-holding counterparts. These include better provision of outreach services, quicker hospital admissions, reduced waiting lists and less unnecessary admissions. They also kept down prescription charges. The allegation made by opponents of the scheme was that there was evidence of the development of a two-tier access to health care as between fund-holders and non-fund-holders. By 1998 some 55 per cent of the population of England was provided for by fund-holding arrangements (Rivett 1998). The counter argument was simple: the fund-holder’s perceived success was due to the generous funding they received from the Health Authorities and further reinforces the under-funding argument made by the BMA. The fact that the new Labour Government from 1997 onwards maintained many of the elements of the Conservative reforms suggests there was some cultural shift and an acceptance the fund-holding scheme had had a positive effect on health care delivery.

1.4.3 Hospital Trusts and Private Finance
Up to the time of the reforms in 1991 NHS hospitals were effectively owed and run by the government. The reforms allowed NHS hospitals to opt out of the collective system and to become NHS Trusts or Acute Hospital Trusts. Those managers who
had a belief in their administrative competence or whose institution was in a position to take the advantage would gain a substantial degree of freedom and autonomy. This freedom was granted on the basis that they would be able to meet acceptable standards of service demanded by the Government coupled with the capacity to reach financial targets. Hospitals would remain in public ownership but would be self-governing entities. Initially this was an option but by 1995 all NHS hospitals had been converted to Trusts. The level of autonomy of a Trust depended on the degree to which, it was judged, the hospitals performed. Performance was now being measured in a way it had not been done before and chief executives came from the business community which led to certain amount of insecurity in that decisions were often made in the short-term time frame of the CEO’s contract (Rivett 1998). This may have led to easy wins and quick fixes. NHS service providers also had to pay a capital charge to the Government in respect of their buildings, land and equipment. This was to encourage managers to make economical use of their capital assets by selling off unnecessary or overly valuable property and to be more careful acquiring new assets. However, a considerable enhancement in the situation occurred in 1992 when legislation was introduced which allowed for private involvement in the provision of capital for public investments – The Private Finance Initiative (PFI) (Talbot-Smith and Pollock 2006). In many instances this resulted in NHS trusts leasing back their facilities and paying the capital charge to a private company. This was the start of Public Private Partnerships (PPP) in the health sector and although greatly opposed by the Labour Party in opposition, back in government, the Labour Health Secretary accepted it: "when there is a limited amount of public-sector capital available, as there is, it's PFI or bust". There is now evidence that although PPPs were considered a cheaper and more efficient method of providing capital, cost overruns have allowed modest projects\(^4\) to grow to such an extent that the capital repayments will cripple the service for years to come. These repayments are guaranteed by the Government to the private financiers for up to 30 years into the future (Shaoul et al. 2008). In addition, most NHS Hospital Trust projects now involve not just the capital from a PFI but full package of design, build, finance and

\(^4\) The city of Coventry planned to refurbish 2 hospitals in 1998 at the cost of £30 million. As the project was considered too small to interest business it was decided to knock the hospitals and rebuild one larger hospital at a cost of £174m. The final cost was estimated to be £410m. The hospital needs to find £56m per year to service capital costs. This will rise in line with the consumer price index for 30 years. Monbiot, G. (2007) 'This great free-market experiment is more like a corporate welfare scheme', The Guardian, 4th September 2007,
operated (DBFO) by a private consortium and therefore the annual fee will cover non-clinical services provided in addition to the capital charge. The controversy arises because the extra financial burden put on hospitals is associated with cuts in clinical services. The average cost of a PFI scheme for trusts is 8.3 per cent of income. However under the Payments by Results (PbR) system of funding, trust income is controlled by a standardized tariff for treatments in which the capital cost component is set at 5.8 per cent (Hellowell and Pollock 2007). The typical PFI involves the hospital trust leasing their new or refurbished facilities and procuring all their non-clinical services from a private sector partner for a period of 30 years. In many cases this locks the trust into an annual deficit, making its long term financial position impossible to solve without Government intervention (Shaoul et al. 2008). The PFI represents a fixed cost which reduces the trust’s flexibility. Evidence compiled by Shaoul et al (2008) suggests that investors in PFIs reap higher than average returns on their investment, pay little tax and create an ongoing inflexible burden on the trusts with a risk premium on the cost of private capital 3 percentage points above the cost of sovereign debt. In addition the contracts allow for several ways in which to increase charges over the 30 year period where the trusts are locked into a monopoly supplier.

1.4.4 Choice
The ability of the market-based reforms to mimic a genuine market was limited (Enthoven 2002, Grubb and Meller-Herbert 2009). Purchasers and providers had insufficient information on the fundamentals to make informed choices. Do ill patients really want to make their own choices? There is little possibility that they will have the level of knowledge, or be able to acquire the knowledge they would need to make decisions. Fotaki (2007) refers to studies on elderly patients requiring cataract surgery. Most did not want to be confronted with choices because of a lack of appropriate information and the fact that the procedure was a highly specialized one. Choice is not an essential aspect of making quasi-markets work. But politicians often stress choice as the main advantage to the public when promoting MBRs (Milburn 2003, quoted in Fotaki 2007).
Enthoven (2002) argues the institutional foundations were not in place in the early 1990’s to facilitate the creation of a market. Purchasers needed to be able to have the ability to demand better services or select a better alternative. Equally, providers were unable to respond adequately to the market forces to which they were being exposed. Introducing competition was supposed to reduce costs and increase quality. While it is possible to estimate costs the measurement of quality is more difficult.

The normal competition that exists in other markets such as computers or mobile communications is not present in health care (Porter and Teisberg 2006). The ‘invisible hand’ of Adam Smith in the marketplace which forces technology into a constant state of improvement is misplaced in the provision of health care. The competition that is present in health care is not that which improves matters for patients in terms of better outcomes for the amount of money spent. Much cost saving efforts concentrate on short term cutbacks and the competition is in the form of shifting costs from one area to another. Competing on results has been offered as the solution to this problem but there are situations in health care where good outcomes are not apparent from any perspective (Teisberg et al. 1994, Porter and Teisberg 2006, Taylor 2004).

1.4.5 Today
The NHS reforms altered incentives particularly for GPs. Consultants found their power base diminished and GPs gained increased influence on the purchasing decisions. Managers had a strengthened position and some professional staff found themselves on short-term contracts which reduced their commitment to their institution and made them less likely to complain about things that they viewed as unsatisfactory (Rivett 1998, Goldacre 2013). Opponents of the reforms were able to point out that the basic dilemma faced by all health services around the world had not been solved – the ever increasing demand in the face of resource constraints.

The Labour Party vowed to put an end to the internal market and restore the NHS to its glory days. In fact they maintained much of the change which had come about under the Conservatives particularly the purchaser-provider split. The new position would be a refinement of the system that had developed rather than a return to the
drawing board (Enthoven 2002). In 1999, after 2 years of the new Labour Government, it once again became clear that to maintain standards in the NHS another big injection of cash was needed. In 1994 the total expenditure on health as a proportion of GDP had been 7 percent. After that it began to drift down again to 6.8 in 1998. The new Secretary of State, Alan Milburn, got a much increased budget and reversed his predecessor’s (Frank Dobson) policy of attempting to unravel 10 years of change in the NHS. Milburn actively encouraged cooperation with the private sector. In spite of the opposition of many forces by 2005 the NHS had been transformed from a state owned facility which provided services for the citizens to a commissioning organization whose services would be provided by a variety of different entities both public and private (Timmins 2005). The purchasing of services from the private sector was a major contributor to the reduction in waiting lists. But it has been claimed that operations carried out by the private sector to a distressed NHS are up to 40 per cent more expensive (Marsh 2004).

After 13 years of Labour Government there exists today a far more aggressive internal market than was ever envisaged by the Conservatives in the early 1990’s (Rivett 1998). There is a renewed level of opposition to the market-based aspects of the NHS. The BMA is actively campaigning against what it refers to as the ‘commercialisation’ of health care. Their arguments are that stimulating a market in the NHS will lead to fragmented and duplicated services with money wasted on bureaucratic costs and a disruption of patient care (BMA 2010). Many of the ‘Darzi Centres’ and Polyclinics are run by commercial or voluntary organizations, a fact that is largely unknown to the public (Healthcare Republic 2008). The BMA claims that these organizations have short-term contracts, which will in turn lead to a high turnover in doctors, thereby disrupting the long-term continuity of care (BMA 2010). The Payments by Results (PbR) system introduced in 2005 has fundamentally altered the way hospitals are funded by doing away with the block grant and contracting on the basis of predicted activity.

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5 So called Darzi Centres are multi-disciplinary medical centres named after Health Minister Lord Darzi.
6 Polyclinics are a more extensive version of ‘GP-led health centres’ based in the London area
It is surprising after 20 years of tinkering with the system to bring about a greater internal market to health care that groups like the BMA are more opposed to it than ever before. They see the involvement of commercial entities in health as a divisive thing creating unnecessary competition where there should be co-operation and collaboration. They believe the purchaser-provider split is expensive and creates artificial divisions between different parts of the health service. PFIs, in particular, come in for sustained critical analysis and are opposed by many commentators and yet virtually all NHS hospitals in England have been financed by this method since 1997 (Shaoul et al. 2008). It is difficult to find any literature actively supporting the continued use of PFIs but advocates of the policy argue that they deliver better value for money and that the public purse is constrained by European Commission Public Procurement rules. Alan Milburn, the Labour Secretary of State for Health stated in 2000:

“...partnerships between the public and the private sector are the cornerstone of the Government’s modernisation programme for Britain. They are central to our drive to modernise our key public services. Such partnerships are here and here to stay.” (Edwards et al. 2004)

1.5 Sweden

Sweden is a country imbued which rich natural resources including timber, hydropower, and iron ore. With a population of just over 9 million people its economy is export oriented (World Bank 2011a). Sweden maintains a policy of military neutrality and was not involved in any wars or conflicts during the 20th century. At the end of the Second World War Sweden had a considerable advantage over its competitors in having its industrial base intact and as a participant in the Marshall Plan used its natural resources to help in the rebuilding of Europe. This is the context in which Swedish governments since the 1940s have created and continued to enhance the welfare state. As taxes increased to feed the expanding government so too did economic prosperity. By the 1980s public sector spending represented 65 per cent of GNP (Glasgow 2009). Swedes believed in collective responsibility for the provision of the less well off in society and this was paid for by a prosperous, peaceful, resource-based economy. Changes in the health and welfare
system were mainly those of greater expansion due to demographic changes. For example the baby boom gave rise to the growth of childcare (Hjertqvist 2002). The level of economic growth did not keep pace with the growth of the welfare system and this trend gave rise to record government deficits by the early 1990s. Coupled with this, financial de-regulation during the 1980s fuelled a property boom which ended with a crash in 1991. This led to a series of bank failures and the economy contracted for two years having experienced only expansion for the previous fifty (Dougherty 2008).

1.5.1 The Health System and the Need for Change
The Swedish health system was almost entirely publically owned before the property crisis of the early 1990s (Harrison and Calltorp 2000). Governance of the health system in Sweden is divided between central government and the counties. The county councils are the principal administrators of the health system. The counties are subdivided into 290 provincial municipalities which are similar to Irish local authorities like Urban District Councils. There are 21 counties (see Figure 1.2). These counties are responsible for financing and providing medical care for their inhabitants as well as promoting public health. The population of the counties varies in size from 60,000 in Gotland to 1.8 million in Stockholm. Seventy per cent of the financing is provided by means of an income tax payable to the council together with a small contribution from the patient and the balance is provided by central government (Glasgow 2009). With tightening budgets during the 1980s and the financial crisis of 1991 the Government was forced to freeze tax revenues to the county councils who in turn had to introduce strict budgets in health spending. In the same year the Social Democrats, who held power with few interruptions for over fifty years, lost out in the general election to a conservative coalition. The new government was a combination of five parties but all were committed to the implementation of MBRs. This was a practical means of combating the effects of the financial crisis but was looked on as the promotion of a neoliberal ideology. It is tempting to view it this way but some movement in this direction had taken place before the conservative government came to power and several county councils who were enthusiastic supporters of the reforms remained in Social Democrat hands.
1.5.2 *Reforms*

The county councils began to introduce reforms to attempt to ‘do more with less’. Many of these were mimicking what was going on in Britain at the time. Central government endorsed the reforms but there was a wide variation in how the various initiatives were implemented. The reforms included:

- The Patient Choice of Hospital and Care Guarantee
- The Family Doctor System
- Purchaser Organizations
- Provider Autonomy

The Patient Choice of Hospital and Care Guarantee were to change the financing of hospitals from the block grant to paying for actual activity: the ‘money follows the patient’ model. This was to provide an incentive for hospitals to increase their productivity to ensure that they treated as many patients in their own catchment area and possibly attract patients from other areas as well. It would also act as a deterrent, for managers and doctors, to allow waiting lists to build up to attract more funding.

Again, like in the UK the concept of choice was sold as a benefit to the population. In the event it proved popular particularly in cities where people had the option of making a choice and waiting lists were cut to a point that they ceased to be a political issue (Harrison and Calltorp 2000).

The Family Doctor System allowed people to choose their own doctor. This could be either a private doctor or one who worked a public clinic. These doctors would get a capitation fee and would ensure a more personalized service in comparison to clinic staff doctors who worked on rotation. Prior to this the majority of doctors were salaried employees of the state who practiced in state-run polyclinics. The new arrangement provided them with an opportunity to boost their pay levels.

Purchaser Organizations were put in place to implement the purchaser-provider split. Previously the councils were the overall providers of health care and delivered to hospitals the finance they needed to perform their work. Now councils would be purchasers of services from independent hospitals on behalf of their constituents.
Medical procedures were analyzed and divided into diagnosis related groups (DRG) and a set charge was ascribed to each particular procedure. This way, hospitals got paid for the actual work carried out and it incentivized less efficient hospitals to improve productivity so as to generate revenues sufficient to cover their costs.

The providers of services were given greater managerial autonomy without any change to their legal status as happened in Britain. With the councils as purchasers
and more independent hospitals as providers it was possible for purchasers to buy services outside their area if better value and more efficient services were available but in practice most stayed within their own area particularly in more remote parts of the country where long journeys for treatment would have been impractical. While the policy did not create much competition between hospitals it did force hospitals to reduce costs and increase productivity (Harrison and Calltorp 2000).

1.5.3 Stockholm Revolution
The twenty-one Swedish county councils displayed marked differences in the way they approached the reforms which were being enacted by central government. As has been noted the variation in population, geography and political governance gave rise to these differences. Stockholm County (AB, Figure 1.2) being the most populous and containing the capital city took to the reforms and enhanced them in a more enthusiastic way than most. Hjertqvist (2002) lists the elements of the reforms necessary when it was clear that the old ‘Swedish Model’ was no longer sustainable:

- DRG system puts a price tag on each procedure. Instead of global budgets service providers are compensated according to the DRG price.
- Competition for contracts is open to a variety of providers both public and private. Hospitals are converted into publically owned companies with some being sold to private sector interests.
- Freedom of choice for patients with a guaranteed waiting time of no more than three months.
- Salaried employees are given training and support to start their own businesses with a view to taking over primary care clinics and other facilities who bid for contracts.
- Provide consumer information to support active consumer participation through information technology.

The revolution began in 1992 and two years later it they found productivity improved by 5 per cent, patient turnover increased by 18 per cent and cost savings were 25 per cent (Glasgow 2009). In the past, budget pressures were addressed by
cutting back activity but with fixed prices for specific treatments it made more sense to increase activity in order to generate more revenue. Being more competitive meant increasing quality, allowing greater access and in some cases reducing prices – a commercial approach. Most of the improvements in the system were achieved by privatization. Many primary clinics were now being run as a business by the same people who previously had been employees in the clinic when it was in public ownership (Glasgow 2009, Hjertqvist 2002). However Stockholm County possessed characteristics not present in all counties and later evaluations of the countrywide situation suggested that in many cases health care costs had risen sharply. Expensive medical technology was acquired in local hospitals and private hospitals emerged which provided high technology treatments often attracting wealthy clients from third world countries. There was evidence of cherry picking by medical professionals which left areas such as care for the elderly in a worse condition (Twaddle 1999).

Productivity improvement and cost reductions were achieved throughout the country but the reforms, particularly the purchaser-provider split, were not universally adopted. This leads to the conclusion that the reforms were not completely responsible for improvements. In 1992 the ADEL reform was introduced. This transferred responsibility for organizing and financing care for the elderly from the county councils to the municipalities (Henriksen et al. 2003). This gave the municipalities an immediate incentive to transfer elderly patients out of hospital and into step-down care as quickly as possible or be responsible for the cost so it led to a major reduction in ‘bed blockers’ and made hospitals look more efficient.

In 1994 the Social Democrats returned to power nationally and in many of the county councils. Many of the changes in the administration of local government and health services were kept in place. There were some reverses: the Family Doctor System was more or less ended as the growth of private clinics threatened the state-run polyclinics. Many of the county councils tightened control over providers and purchasers which undermined the function of the purchaser-provider split. The result of the changes after 1994 was that there was to be an emphasis on co-operation rather than competition. Nevertheless, a good deal of the culture surrounding the operation of the health services was altered by the experiments in MBRs of the early 1990s.
1.6 Australia

Australia is a country and a continent with a population of approximately 22 million people who inhabit a land mass of over 7.5 million square kilometres (World Bank 2011a). It is endowed with large and diverse amounts of natural resources. Europeans began exploring Australia in the 17th century and during the 19th century six British colonies were created there. In 1901 the Commonwealth of Australia was formed – a self-governing federation under the British crown with six states and two territories. The population growth is still very influenced by immigration with a surprisingly large contribution coming from New Zealand. The majority of the Australian population lives in urban areas and large parts of the country are uninhabited (Hilless and Healy 2001). Government in Australia is delivered at three levels: the federal or national government known as the Commonwealth, the state or territory government and local government which can be called cities, shires, towns, or municipalities (Australian Government 2011).

In common with many countries in the post Second World War era the Labor Government tried to radically reform the health system and build a country ‘fit for heroes’. Every such move was resisted by doctors, insurance companies and conservative politicians. The Australian Medical Association opposed efforts to ‘socialize medicine’ through actions in the High Court which were successful. As a result of a referendum the Labor Government managed to introduce a limited range of measures to reduce financial barriers to medical and hospital care through the Hospital Benefits Act 1946. The Pharmaceutical Benefit Act 1950 and National Health Act 1953 set up the post-war Australian health system during a time when conservative governments ruled.

1.6.1 Medibank and Medicare

Back in power in 1972 the Labor Government set about introducing a national health insurance system called Medibank which finally made to the statute books, amid a constitutional crisis, in 1975. This was designed to provide universal health insurance administered by the national government and funded by taxation. Patients
could claim back 85 per cent of their out-of-pocket medical expenses from the Health Insurance Commission or doctors could bill the Commission directly and accept 85 per cent as full reimbursement also known as ‘bulk-billing’. Hospital costs were shared by the national government and the state government and provided universal free access to public hospitals. With the return of the Liberal Government in 1975 alterations were made to Medibank which allowed individuals to opt out of the scheme with a higher levy on the incomes of those who chose to remain in the scheme – effectively changing it to a voluntary insurance scheme. Labor Governments in the 1980s re-introduced universal insurance now named Medicare. At that time 50 per cent of Australians had private health insurance (Hilless and Healy 2001) showing a lack of faith in the public system evident in Ireland today.

1.6.2 Reforms
Unlike Britain and Sweden, Australia did not have a comprehensive, free at the point of delivery, universal health system that stretched back to the 1940s. Nevertheless the pervasive influence of New Public Management gained currency in Australia. By this time the bitter ideological divides regarding health care were a thing of the past with both strands of the divide supporting Medicare and universal health insurance. Many countries of the world have struggled to contain health care costs (Rivett 1998, French et al. 2001, Hjertqvist 2002, Healy et al. 2006). With medical costs rising at a rate faster than general prices there is always the suspicion that resources are being wasted or at least greater value could be achieved. Australia, with its less direct, more convoluted form of government introduced changes on an incremental basis – things may be agreed on a national level but then need to be negotiated individually with the states.

After universal health care access was re-introduced the numbers of individuals holding private health insurance fell from 50 per cent to 30 per cent as confidence grew in the public system and many saw private insurance as an unnecessary expense unless they anticipated significant need (Kreindler 2010). This resulted in the private insurance sector becoming unprofitable due to the fact that they were now insuring sicker people and it put a greater burden on Medicare. Both situations were unsustainable and undesirable outcomes. To counteract this the government
introduced a range of measures to make private insurance more attractive and to ensure those who could afford it had insurance rather than relying on the public system (Colombo and Tapay 2003). The level of the population covered by private insurance increased to 45 per cent as a result. The encouragement of the private sector did not however reduce pressure on the public system. Instead it created new demand, in the private sector, from lower risk, younger patients for shorter, day care procedures which were more profitable and the labour intensive work was left to the public hospitals. Encouraging greater private involvement both in the provision of service and the funding through insurance does not appear to solve the problems of supply, equity or efficiency (Kreindler 2010). Getting the balance right between the public and private sectors was the greatest challenge in Australian health care. Private insurance continues to be important in the Australian system because it is the main component of the funding of private hospitals which constitutes one third of the stock of acute beds (Healy et al. 2006). This is also important for the provision of greater capacity in ‘day-in’ surgery which accounts for half of all surgeries and therefore excess problems with the private sector impacts directly on the entire health care system.

From the early 1990s state governments changed the way they funded hospitals. Up to that point hospitals had been funded on a historical basis – the block grant provided partially by state and partially by the Commonwealth Government. A DRG casemix system was introduced whereby a specific price was paid to hospitals for each individual procedure (Willis et al. 2009). State governments also experimented with contracting out public health care to private hospitals and privatizing public hospitals. It was claimed that greater efficiency was achieved in the states that were most advanced in implementing these measures together with greater purchaser-provider split (Podger 1999).

As noted earlier, in health care, supply appears to drive demand. By the beginning of the new century expenditure on primary care had increased significantly. Although Medicare payments increased in line with inflation the expansion of the profession due to immigration and the way general practice was managed led the Government to take measures to limit expenditure. The number of medical practitioners was curtailed by limiting overseas doctors, reducing the intake to medical schools and restricting the number of GPs who could bill Medicare. The Medicare rebate (85 per
cent) to doctors acted as a constraint on fee increase but with the decline in doctor numbers the amount of bulk-billing declined and a lot of patients were incurring out-of-pocket expenses. To address this, the Government increased the Medicare rebate to 100 per cent (Healy et al. 2006). Growth in the cost of pharmaceuticals was addressed by the mandatory economic evaluation of all drugs in use and recommending the use of generic drugs where appropriate. With the Australian system of government, having a bicameral federal administration, states and local government, changes will continue to occur at a piecemeal pace due to the need for all issues to be carefully negotiated through the various rungs of government. It might be noted that different states and territories will have different budget constraints at any given time (Podger 1999, Healy et al. 2006).

1.7 New Zealand

New Zealand is situated in the South-Western Pacific Ocean about 1500 kilometres east of Australia. Its land mass consists of two islands known as the North Island and the South Island and numerous smaller islands. The population of New Zealand currently stands at 4.3 million people, 90 per cent of whom live in urban areas (World Bank 2011a). The capital is Wellington but the city of Auckland is by far the largest city with a population of 1.4 million. Up to the 1970s New Zealand’s principal industry was the production and export of food and agricultural products mainly to Britain and the United States. In the 1970s Britain joined the then EEC which reduced the amount of exports to that country and at the same time the oil shock of 1973 sent the economy into depression. Its living standard fell from one of the highest in the developed world to the lowest. This led to a major restructuring of New Zealand to a free trade industrialized economy.

The indigenous Maori people were Polynesians who settled on the islands in the 13th century. Europeans first came there in the 1700s when the English penal settlements were established. New Zealand has been a self-governing British colony since 1840 and in 1907 it declared itself a Dominion of the British Empire. New Zealand has been a progressive country. It was the first country in the world to give women the vote in 1894 and because of the depression of the 1930s it re-invented itself as a
welfare state ahead of most European countries. Public hospitals were funded by the Government as far back as the 1880s. New Zealand is a parliamentary democracy and government is carried out by cabinet headed by the Prime Minister. The upper house of parliament was abolished in the 1950s and therefore New Zealand has a unicameral legislature. Underneath central government there are 12 regional councils and 74 territorial authorities.

1.7.1 History and Economy
New Zealand established a department of health headed by a cabinet minister in 1903 and so was one of the first countries in the world to do so. Universal health care was established under the Social Securities Act 1938 following the election of the first Labour Government in 1935 (French et al. 2001). Comprehensive free health care funded by taxation was available for all. Resistance to this system came from the usual source – the medical profession. Doctors insisted in staying independent and negotiated a subsidized fee-per-item system of reimbursement. In spite of the depression of the 1930s New Zealand remained a relatively prosperous country and the Second World War brought greater demand for its commodities. New Zealand was largely unaffected by the war and soaring commodity prices in the 1950s saw prosperity reach new heights with per capita income reaching 88 per cent of that of the United States (Reserve Bank of New Zealand 2007). Economic difficulties started to affect the country in the 1960s with the collapse of wool prices and the changes of the early 1970s meant that a major re-think was needed in the way the economy was managed. Up to this point the economy was highly regulated but the 1984 general election brought in a new Labour Government which started the process of cutting the scale of regulation and state involvement in industry and opened up the country to international competition.

1.7.2 Public Development and Private Insurance
In the years between the 1940s to the 1970s what had been a centrally funded and managed health service changed to a more devolved system with greater autonomy at hospital level. Greater decentralization occurred with the creation of 14 area health boards in the 1980s. Each area had at least one large district hospital around which the services were administered. Primary care continued to be administered on a national basis. The Department of Health provided funds to each health board which
was using up two thirds of the government budget (French et al. 2001). During this time when public spending on health care was at its highest 51 per cent of the population held private medical insurance. This, similar to Australia and Ireland, suggested a lack of faith in the public service. At that time both the rate of premiums and the claims were low. By the early 1990s the level of claims had jumped substantially due to an ageing population and led to a large increase in premiums. Community rating in private insurance means that all age groups pay the same premium and with the jump in premium costs many younger, healthier policy holders gave up their insurance. This led to a crisis in the private health insurance market and forced the insurance companies to adopt ‘age banding’ in premium charges which increases the cost of insurance for older people substantially (Mays and Devlin 2005). In common with most developed economies health spending continued to grow and the after a change of government in 1990 to the National Party (conservative) a taskforce recommended the health system bring in market oriented reforms and attempt to achieve ‘value for money’ without creating any barriers to quality care. One of the principal recommendations was a separation between the provision of services and their purchase – the purchaser-provider split. The 14 health boards were disbanded and were replaced by 4 regional health authorities. These authorities were given a budget to purchase all the health services, primary and secondary, in their area from both public and private sources. A Public Health Commission was set up to coordinate the provision of public health services and Crown Health Enterprises were set up to run the hospitals and other service providers on a commercial basis. By 1996 the Government concluded that the reforms had not worked and that co-operation and collaboration would replace competition as the principles in the provision of health services. Three of the four regional authorities had developed large deficits and the Government had little choice but to make up the shortfall. The Labour Government elected in 1999 began reversing all moves towards quasi-markets believing that strict competition was never likely to be viable in health. The Crown Health Enterprises were re-named and relieved of their obligation to make a profit.
1.7.3 Failure of Reforms
The quasi-market reforms had failed. Some cost containment was claimed to have been achieved but no real competition emerged and the choice to the consumer remained as it had been. The waiting lists for elective surgery had increased. Local authority over health administration was re-established by the creation of 21 District Health Boards funded directly by the government ending the purchaser-provider split. At the end of over twenty years of intervention and changes, the health system is largely back where it was in 1980. Publically funded hospital services are free at the point of demand but charges apply to primary care and pharmaceuticals which are partially subsidized except for means tested exemptions and GP visits for children under 6 and maternity care (Mays and Devlin 2005).

1.8 Conclusions

In examining these countries it is striking that all of the market oriented reforms commenced at the same time. The problem of medical inflation, driven by relentless technological advances continues to drive up costs at a rate that normal GDP growth cannot keep up with. These problems surfaced in the NHS in the 1960s and the only solutions were either the unthinkable return to the pre-war health care system or carry on with an injection of extra funds. In Sweden, with their unique upward only economy and complete community support for the ‘Swedish Model’, no alternatives were needed until the economy was adversely affected by the collapse of a property bubble. Australia’s struggle to get a national health system started was always hampered by the cumbersome government system and it slowed the pace of reform which may have been a blessing in disguise. In marked contrast New Zealand with its direct simpler government system was able to effect radical change fairly quickly and reverse it as quickly again when the hoped-for benefits did not materialize. New Zealand has largely abandoned the market reforms in health. In Sweden, although many of the reforms were reversed there is now a greater private sector involvement than the days before the first reforms. There have been certain residual benefits from the experiments – successful or not. In Sweden some of the culture of free enterprise has left its mark on health professionals such as a greater understanding of the need to control costs. The population as a whole will not be as complacent about the
miracle of the ‘Swedish Model’ into the future. In Australia and in New Zealand efforts to encourage the private provider sector and private health insurance seems to have produced perverse incentives which had the effect of damaging the sector itself and given rise to greater costs. Similar effects have been seen in Ireland with the National Treatment Purchase Fund (see Chapter 3). It is in the United Kingdom where over twenty years with governments of both left and right we have seen the NHS ‘unbundled’ and transformed into a commissioning organization. The history of the NHS suggests that its smooth operation is directly related to the amount of funds it receives. In 2008 UK spending on health was 8.7 per cent of GDP up from 6.7 per cent in 1998 (OECD 2012). An irreversible potential time-bomb for the NHS is the Private Finance Initiative which has locked the NHS in with private investors for thirty years whereby most of the advantages seem to lie with the investors. Whether fully in government hands or with a certain amount quasi-markets health services of the world will always have problems. No society is static and new problems relating to demography and economics will always emerge but the countries with less obvious problems in their health services are the ones who spend most in relation to their GDP.

The changes in health service delivery which have taken place in these four countries sets the context for the examination of similar issues in the Irish case. The United Kingdom was the key mover in the shift to private financing and the use of the private sector in resolving capacity issues in their health service. Australia and New Zealand as former colonial outposts of the British Empire share much of the legal-cultural background with Ireland. New Zealand’s population is almost the same as Ireland’s but their unicameral government system allows for faster action and reaction. Ireland’s slow process in all legislative progress has more in common with Australia, which, due to its size and structure has a built-in brake to radical change. In some respects this may not be a bad thing. Although there had been an aspiration for an ‘Irish NHS’ when the Department of Health was set up in 1947 there was also the immediate recognition that such an undertaking was beyond the financial reach of the state at the time. Even if it had been feasible, much adept maneuvering from the medical profession and the Catholic Church, to prevent the ‘socialization of medicine’, made sure that it did not materialize in the 1940s or 1950s (Lee 1989). The true motivation for the medical profession in Ireland, similar to the position in
Australia, was the potential loss of income. Although many reforms have taken place in the meantime, Ireland today has been left with a health service which is a hybrid of public and private, funded by taxation, insurance and out-of-pocket payments. It is often referred to as a ‘two tier’ system in which the public side is characterized by delays and long waiting lists for treatment and on the private side the best of treatment services are available to anyone who is prepared to pay for them. All residents in Ireland are entitled to health care through the public system and treatment is either free or different fees are charged depending on income levels. It is a testament to the lack of confidence in the public system that almost fifty per cent of the population have private health insurance. There is an inherent feeling among the population that government undertakings are, by their nature, wasteful and inefficient. On the other hand, the same undertakings, if provided by the private sector, may draw the suspicion that excessive profits are accruing to private interests by virtue of limiting the benefit to people in need who believe that they are entitled to the service. This thesis is about mixed delivery in health care and the example how similar models evolved in comparable countries has set the scene for Irish-based analysis by providing a broad sweep review. In setting the context for examining the rationale for favoring the public over the private sectors in health care or vice-versa we now proceed to look at the theoretical issues to affirm research questions and then continue with empirical examination of cases.
Chapter 2:

Theoretical Perspectives on Ownership and Institutional Change

2.1 Introduction

This study follows a long tradition of seeking to understand differences in the behaviour and performance of public and private organizations as well as measures designed to implement models of mixed delivery in the health services sector. Understanding such differences has long commanded the attention of academics across different disciplines. In the latter part of the twentieth century theoretical perspectives on ‘government failure’ such as property rights and public choice theory were particularly influential in terms of shaping a wave of market-oriented reforms such as: privatization, de-regulation and different types of quasi-market measures (Le Grand 1991). Although contested, these perspectives shed light on differences between public and private ownership and provide a strong rationale for the questions we frame around the question of performance in the context of models of mixed service delivery that prevail in the Irish health services sector.

The development of mixed delivery models observed in the Irish health services sector has involved the introduction of features such as competition and private sector participation which has brought fundamental change to the delivery of health services. These changes in the institutional framework have the potential to alter the structures for behaviour and thought of those responsible for service delivery. Perspectives on institutional change are therefore explored in this chapter for the purpose of understanding the institutional factors that influence behaviour and actions that impact on service delivery.

Walsh (1995) notes that institutional change in the context of public service delivery can be complex and can be resisted by those who benefit from existing institutional arrangements and also because ‘institutions exist not only as external systems of constraints on behaviour but also internal patterns of systems and values’ (1995, p.31). In this context a framework for examining the factors that shape institutional
change is presented in this chapter which is later adopted to illuminate cases of institutional change in the Irish health services sector.

Figure 2.1: Conceptual Map Chapter 2
A thesis aiming to understand ownership in health service markets needs several theories to frame research questions. Because our focus is on the Irish case, we aim to look at the principal theoretical perspectives that can help to answer our questions about performance and proposed reform.

To that end, this chapter is laid out as follows: we examine the concept of health as public good in section 2.2. In section 2.3 we review the theory of public choice. In section 2.4 we look at the theory of ownership and property rights. Section 2.5 reviews the literature on transaction costs, section 2.6 on institutions and rules, and section 2.7 deals with institutional change.

Figure 2.2 shows the direct relevance of each theoretical lens for each individual case study. Of course each theory reinforces, and leans on, the other, in terms of informing the work of this thesis and the type of outputs generated. This figure exists as a guide for the reader as to the major connections.

**Figure 2.2: Theory and Cases Map**
2.2 Health as a Public Good

A ‘public good’ is something which individuals cannot be excluded from and the use of the good does not reduce its availability to others (Guinness and Wiseman 2011, Hess and Ostrom 2007). Typical examples are: knowledge, air and lighthouses. A public good usually bestows a benefit to the community in excess of its cost and it is likely that its economic and administrative burden may well be beyond the ability of individuals and firms. Public goods have externalities that deliver value to those who do not consume it directly. In health care the consumption of vaccination for infectious diseases on the part of an individual will be beneficial to others in that it will reduce the chances of the spread of the particular disease. If the free market was to govern these transactions, with the assumption of the utility maximizing consumer and demand reflecting the self-assessed benefit to individuals it is fair to suggest that they may not place a value to society’s benefit so we can assume that provision and consumption of the vaccination would give rise to a market failure (Guinness and Wiseman 2011).

2.2.1 Private Sector Involvement in Healthcare

The preceding discussion raises an important question. If we have established that collectivized healthcare is the choice of society, and it frequently delivers positive externalities, and the free market may fail, then why should we tolerate private sector involvement in healthcare at all?

The market for healthcare is not one dimensional, it covers many separate spheres of activity some of which could benefit from market competition and many which display all of the characteristics of public goods. The organization of many aspects of public service falls on the state due to the fact that some services, which society demands, are overly complicated, difficult and too large to be undertaken by individuals or corporations. In healthcare, private sector involvement is often confined to areas where it is possible to make a profit, that is, where the system could benefit from competition, and it is clearly not possible to do so in all cases. As it is, much of the revenue accruing to private healthcare comes directly or indirectly from the state in the form of payments, subsidies and tax relief for health insurance.
Governments are heavily involved with the business of the provision of healthcare. This means the policies that govern decisions taken about our wellbeing are made by what we describe as ‘policymakers’ and are filtered through the political system and the results are shared by all.

2.3 Public choice Theory

It is widely recognised that organizational performance (which can be measured using different metrics) is a complex function of a host of variables including ownership, competition and internal governance (Dunsire et al. 1988, Martin and Parker 1997, Stiglitz 1991, Vickers and Yarrow 1988). Perspectives from property rights and public choice theory focus largely on the question of ownership and have been influential in terms of underpinning market based reforms and privatisation of public services.

Different ownership types may have different objectives, diverse incentives and a great variation in the level of monitoring. Public choice theory assumes that *Homo economicus*, all individuals in society will pursue their own self-interest. Public choice theorists may assume that public and civil servants are not ‘mindlessly’ following orders for the ‘greater good’ and make and implement decisions to maximize their own selfish interest or the interests of their group. The same can be applied to public representatives (Reeves and Palcic 2011). Williamson (2000, p.603) asserts that the public service has: ‘lower-powered incentives, more rules and regulations, and greater job security’, therefore there is less incentive to control costs. Government failure may be ascribed to the possibility that politicians and bureaucrats are pursuing separate self-interests neither of which can be expected to be in the public interest. Managers of public organizations are also likely to expand the sphere of influence or the magnitude of their bureau beyond its efficient size (Niskanen 1975, Tirole 1994, Williamson 2000). The result of this is likely to be allocative and technical inefficiency.

It is possible to argue that while ownership is not the deciding factor *per se*, the way authority and governance is exercised, in different forms of ownership, can give rise to the factors that directly impact on the efficiency and effectiveness of an
organization. In many cases, the public sector is engaged in different economic activities than the private and in the few instances where clear comparisons can be made output is difficult to measure.

Membership of any private organisation is voluntary whereas membership of the state is compulsory and the state has powers of compulsion not available to the private sector. Making a similar point but with reference to the health sector, Duggan (2000) suggests the critical difference between public and private sector hospitals is the existence of soft budget constraints on government-run institutions.

Many assumptions regarding public and private organizations seem to be born of what Rainey and Bozeman (2000 p. 448) refer to as ‘a priori’ knowledge or untested assertions and foregone conclusions in the distinction between public and private organizations in managerial research. Many of these untested assumptions, involving negative views of public organizations and the innate superiority of private firms, remain stubbornly in place, despite the accumulation of empirical research pointing to their similarities. Simon (1995) argues that careful comparative studies have found it difficult to identify differences between profit-making, non-profit and publically controlled organizations.

A difference between the two sectors often referred to is the complexity of the goals of public organizations in comparison to their private counterpart and the difficulty in measuring these goals. However Rainey and Bozeman (2000) assert questionnaire surveys spanning fifteen years taken with managers on many levels in public and government agencies and private firms suggest public managers do not agree that the clarity of their goals and the ability to measure performance is any different from that in the private sector. Dixit (2002) suggests that the inappropriate and naïve application of solutions such as competition or performance based incentives in an effort to mimic the private sector can give rise to these problems. Incentives need to be selectively targeted if they are to be effective.

The distinction between public and private organizations in the mind of the individuals in society is likely to be connected to the ownership and control of the organization. People are more likely to be concerned with those public organizations with which they have some form of interaction such as the health services and less likely to be bothered about entities with which there is less contact such as the
production of industrial chemicals. Nevertheless the performance of public organizations when compared to private organizations may not have any connection with the ownership of that organization.

Andrews et al (2011) argue what matters for the performance of a public entity is the quality of management and the type of organization. Good performance diminishes the ill-effects of public ownership. Public organizations are controlled by political forces whereas private organizations are led by market demand and competitive concerns. Political force will ultimately be aligned to voter demand which may be similar to market demand. The only missing element for many public organizations is external competition. Public bureaus in a democratic system must at least attempt to aim for equity in the delivery of services, and competition has been shown to have an adverse effect on equity (Le Grand and Bartlett 1993, Boyne 2003).

If the difference between the two sectors was management then you might expect individual employees behave differently depending on which sector they are working in. But studies over a considerable period of time into employee behaviour have failed to demonstrate any differences between employees in the public sector with employees in the private sector. Baarspul and Wilderrom (2011) examined 28 organizational level studies from 1974 to 2007 which were concerned with contrasting employee behaviour in the two sectors and they find no clear unequivocal empirical evidence to support the hypothesis there is any significant difference. Differences of who controls institutions will come about if there are institutional changes. This involves changes in relation to property rights and the rights of control exercised by different groups.

2.4 Ownership & Property Rights

Does ownership or the change in ownership from public to private bring about changes in institutional performance? This question can be addressed in terms of an understanding of property rights. For markets to work effectively property rights and the rules governing who, or what group, have the right to exercise control over assets, land or other resources are necessary. Ownership, in the ordinary sense of the
word, suggests the exclusive use of a certain resource without limitations. However, limitations exist. Ownership of a piece of land does not give the owner the right to carry on activities on that land which have an adverse effect on neighbouring land owners (Coase 1960). Ownership of a car does not grant the owner the right to drive anywhere at any speed. Ownership is not an absolute right but it does confer rights on the owner, within limits, to gain economic profit and general benefit from the fact of ownership. The limitations can vary depending on the type of resource and its scale.

Rights which come with ownership have varied over the centuries. Rights enjoyed by landowners in the past have been curtailed by statute. So, ownership grants the right to exercise certain privileges for a limited time (perhaps a lifetime) over the resource. Long leaseholds (999 years) are considered to be equivalent to outright freehold. Possession of a small amount of shares in a large company usually carries with it the proviso that the shareholder has ceded management decision rights to a group of professional managers who are the de facto owners of the business (Demsetz 1967). Demsetz (1967, p.358) writes that: ‘shareholders are essentially lenders of equity capital and not owners’. To have it any other way would be to impose enormous transaction costs on the firm and make effective management impossible. Ownership of an asset can be gained or lost in a number of ways: gained through purchase or inheritance and lost through sale, theft or by order of a court.

The rights that come with ownership can be contracted away to another party who can then exercise the rights specified in the contract. A number of parties may have the right to the use of different parts of a resource. A piece of land may be purchased by an individual for a specific purpose but there may be an existing right of way through it held by someone else or by the community in general. The various property rights which can be contracted away involve a transaction. All transactions are concerned with the transfer of property rights which involve a contract. Consequently, transactions are concerned with the structure, organization, transfer and enforcement of property rights (North and Thomas 1971).

Ownership in relation to a public institution impacts the potential performance of that organization by comparison to a similar institution in the private sector due to the diffused and uncertain nature of the ownership. Ownership is vested in ‘the
people’. But ‘the people’, citizens and taxpayers, like the ordinary shareholder in a public company, do not have the ability to exercise control except in that they, collectively, can pressurize those who have political control. Politicians in a democratic system must maintain a rough balance and often try to appear to please many different and diverse interests at the same time. The professional manager within the institution must consider the smooth running of the enterprise to expected norms of human resource management and legal constraints whilst operating in a marketplace possibly dominated world-wide by privately owned and commercially driven competition. State run enterprises were often criticized for not making a profit in the normally accepted meaning of the term. Some, like CIE, Ireland’s state owned transport company, had no possibility of making a profit due to the nature of its construction and expected duties to the community. Nobody expects the national army of any country to make a profit or else go out of business. Management in these enterprises was often marred by what Dunsire (1988) described as ‘blurred accountability’. If an organization was setup with predominantly social objectives then it is hardly fair to judge it purely on financial performance (Stiglitz 1991). Public and private organizations tend to be involved in different services and therefore there are few instances where direct comparisons can be made.

In the context of public services and different mixes of ownership and delivery ‘the important consideration in the distribution of property rights is what it is that different groups and individuals are allowed to do with resources’ (Walsh 1995 p.39). Property rights will change if ownership, or effective ownership, for the delivery of services alters. In this consideration we are not simply referring to the issue of possession but the global set of relationships and the potential for alteration of those relationships as attempts are made to introduce institutional change. It might be noted that we are not only considering outright change of ownership but the changes within hierarchical organizations or the ability of private organizations to gain benefit from surpluses generated from public capital. Changing the rules on whom, or at what level of authority, within a public entity, has the power to make financial decisions changes the relative property rights of the various actors within the system. When examining moves towards privatization, market-based reforms or changes within the existing system the configuration of existing property rights and the new changed property rights will shape the effectiveness of the evolving entity.
Equally, when considering performance, for example in our cases of nursing homes, hip replacements and cataract extractions the balance of existing property rights shapes the way the delivery of services is processed and who has the power to change or prevent change.

2.5 Transaction Costs

Transaction costs include costs of describing, agreeing, and monitoring contracts including the costs of monitoring employees within the firm (Coase 1937, Allen 2000, Williamson 1975, Wallis and North 1986). Transaction costs are incurred in every interaction or exchange that takes place between any two individuals or groups. Apart from social interdependence and all that entails we focus on transactions which occur in business either between individuals or firms or within firms.

Williamson (1975, 1985) addresses the relative efficiency of co-ordinating exchange using the market mechanism versus bureaucratic forms of organization. The basic argument is that the most efficient mechanism for co-ordinating transactions depends on the relative magnitude of transaction costs. This question arises in the context of public services. The level of transaction costs is the issue which could decide whether the public or private sectors are best suited to provide health services and there is some (albeit limited) evidence to suggest that the magnitude of transaction costs can be appreciable. One example is provided by Hsaio (1995) who found that in unregulated health insurance markets transaction costs have been observed as high as 45 per cent of the premium income.

In healthcare, transactions occur both within hierarchical organizations, in markets and within hybrid arrangements. The function of these transactions is the production and the organization of care. Transaction cost economics (TCE) provides a rich conceptual framework for analysing health care transactions, how they are organized, delivered and paid for.

Most modern economies are a mixture of market and planned management. The price mechanism of the market coordinates allocation and is mostly self-adjusting.
but may take time to reach equilibrium. Competition ensures the survival of more efficient methods of production and distribution. Whether the market mechanism or the hierarchical and bureaucratic method of operating is favoured depends on the efficiency of one over the other. This efficiency is measured in terms of the level of transaction costs. In very complicated transactions a hierarchical form may give rise to lower transaction costs than a market form. Effective use of the market can depend on information and the assets used in the transaction. Institutions will evolve in different parts of the economy which keep transactions costs to a minimum. Which type of institutional form emerges will also depend on other factors such as bounded rationality, opportunism and asset specificity.

We examine two cases of professional services (hip replacements and cataract extractions) where the institutional form is mixed. Transaction cost economics assists in understanding if these arrangements are efficient. Public services such as health have a great deal of highly professional and specific skills which can give rise to bilateral monopoly. The dangers of opportunism by those in possession of the specific skills (educational assets and experience) can be avoided by employing professionals in a hierarchical form of organization and thereby not incurring the costs of bargaining in a bilateral monopoly.

Williamson (2000) is concerned with the issue of bounded rationality and opportunism and the combined effects of these two factors in occasional market failure. All economic actors attempt to maximize their self-interest. Opportunism may be described as: ‘interest seeking with guile’ (Walsh 1995). That is the deliberate exploitation of a strategic position against another economic actor knowing that they are not in a position to prevent it. One party to a contract may be in possession of better information or may have greater resources and can use the position of strength to its own advantage. Opportunism is always possible where there is lack of perfect information. With the misrepresentation of true intentions a financially weaker party could take advantage of the trust of others. Opportunism may also arise where a market has limited number of buyers and sellers and the contractor has little choice but to deal with a party despite evidence of previous maleficence.
A firm’s assets that are dedicated to a specific purpose involving a trading relationship with another firm can be termed as specific assets. The characteristic of these assets is that they have a greater value within that relationship than they have for other purposes outside of that specific relationship. If a firm makes an investment in specific assets in order to complete a contract with another firm it puts itself under the threat of holdups (Klein 2009). The firm which has made the investment will depend on the strength of its contract and an element of human trust, to ensure that its investment isn’t the subject of a holdup by the second firm.

The second firm, knowing that the investment has been made, may take the opportunity to pressurize the first firm regarding ‘incomplete’ aspects of the contract. The investing firm now has sunk costs in the investment and without resorting to the expensive transaction cost involved in seeking a remedy in the courts may have no choice but to agree to the unreasonable demands of the second firm. The investment would not have been made unless it had a distinctive financial advantage and therefore the economic difference between its specific assets and its non-specific assets could be said to be a premium. The second firm may feel that it is entitled to a share of that premium as the premium derives from its engagement with the contract. Being aware of this potential, firms entering into such an arrangement are likely to have contracts that avoid the difficulties of holdups. But in avoiding opportunistic holdups by the terms of the contract, the investing firm may create holdups of its own particularly where it is an exclusive supplier of an upstream component of a process for the second firm.

Joskow (1988) argues that the issues of asset specificity and incomplete contracting are the two crucial factors in causing simple spot market transactions to be plunged into complex transactional difficulties. When the investment becomes more specific, it moves away from a simple spot contract and gets closer to internal integration. Disputes arising within a firm can be resolved in a more autocratic manner and need not have to resort to legal remedies which would be necessary in the case of disputes between independent firms. Difficulties of a less serious nature may not need legal resolution but may require managers of two independent firms to maintain a relationship where persuasion is required to achieve goals. If two firms were integrated, problems could be resolved by the use of authority within the new entity.
Transaction costs between firms may be large and contracts cannot be expected to cover every possible contingency which may transpire over the period covered by the contract. It is in these ‘missing’ or unclear parts of the contract that a third party, such as a court of law, could be required to be consulted to resolve a dispute. If it were possible to construct a complete contract then all potential eventualities would be solvable in a costless way. Some of the incomplete parts of a contract may be ‘filled in’ over the period as issues arise. What Hart (1988) calls ‘residual rights of control’ are connected with ownership of the assets. When a variation in a contract is required the owner of the asset has the power to decide on that variation other than on the parts of that power which have been contracted away. A party who is not the owner of the asset may have certain residual rights of control by statute or due to contract and therefore ownership is not absolute (Hart 1988).

Contractual arrangements need to be quite prescriptive in the areas where hold-ups are liable to happen. Due to the imperfection of contracts it is likely that both parties will try to develop strategies to prevent hold-ups or other opportunistic behaviour or recognize that there will be an economic cost to the arrangement (Klein 2009). Where the contract proves to be overtly advantageous to one party it is likely that the facilities will ultimately come under the ownership of that party. Where these parties are public (government owned) and private respectively the perception of where the advantage lies may determine the outcome – government may buy out a private partner under political pressure but at an enormous cost. Brown and Potoski (2005) argue that when high asset specificity is combined with difficulty in measurement of services transaction costs are likely to be high.

The provision of services by the state can be because of the high transaction costs or because of the inability of the private sector to provide the services without market failure. If market failure is caused by high transaction costs the resulting institutional response is likely to be hierarchical. In order to gain a greater insight into institutions it is instructive to examine the principal elements that form an institution.
2.6 Institutions and Rules

‘An institution is self-sustaining, salient patterns of social interactions as represented by meaningful rules that every agent knows and are incorporated as agents’ shared beliefs about how the game is played and to be played.’ (Aoki 2006)

2.6.1 What is an Institution?

An institution may be regarded as a set of rules governing the behaviour of individuals within the structure of that institution. We might think of an institution as a large building which houses an organization whose members adhere to certain structures and procedures so that we can easily recognize who belongs to that institution and who does not. Yet certain norms and structures are in place and the general rules governing that institution only change slowly over time. In primitive societies people banded together for the purpose of defence, company or the provision of the most basic conditions of welfare: shelter and food. As habits began to form around this co-operation, however informally, the first institutions were being formed.

Habits and routines are at the foundation of institutions. These habits and routines evolve into rules and conventions that form the structure of the interactions between individuals. Our language, currency and the laws that govern our society are all institutions. Institutional rules allow us to have an anticipation of what to expect in a given situation. They give consistency to behaviour which helps us to put some order on our thought process. Institutions do not necessarily rely on the individuals who invented the rules to be present for that institution to survive. Many institutions survive and prosper long after the founders are no longer there. The rules, in constitution, buildings, or retained in the continuous memory of the on-going membership allows the institution to be maintained. A rule is a principle which governs the procedure which must be undertaken when a particular set of circumstances occur.

Early institutions may have been confined to family groups. But communication between group members was essential so that a common purpose was established. The development of language was an early institution which enabled the
development of more complex institutions. Searle (2005) argues that human societies require a deontology\textsuperscript{7} and this is not possible without language. Language forms a social contract and could be considered as the fundamental social institution (Searle 2005). Rules become habits once they are established as routine. Basic routines of everyone’s day may have long since become so predictable that no specific original thought process needs to be exercised. They have become virtually involuntary. Rules established by the need to survive, need not be formed by the deliberate actions of certain individuals. Rules are followed for the reason that they make sense to the members of the group or that the act of breaching them would lead to a level of discomfort for the rule breaker.

These rules, whether formal, informal, customs and norms or legal, have the potential to be codified (Hodgson 2006). Codification of these formal rules, particularly involving property, government, judiciary and bureaucracy into enforceable laws moves the analysis to a different level (Williamson 2000). With the codification of these rules the potential exists to demonstrate breaches in the rules which identify them as institutional rules (Hodgson 2006). An institution can be a structure involving individuals where there are a set of identifiable rules. The breaking of these rules leads to adverse consequences. Some writers make a distinction between norms and rules. Norms are taken to be human actions and words that arise due to the individual’s expectation that others in the group subscribe to the same beliefs and aims and need not be codified. Rules and laws might gain a moral power of their own or be observed because of the penalties for breaking them.

Embedded habits and rules may be described as part of human nature and culture and are likely to change only very slowly over time (Granovetter 1985). These embedded rules are manifested in shared behaviour and thought processes understood by a group of individuals thus giving rise to an institution. The continuous repeating of habits reinforces the institution and induces greater conformity on its members. The established institution provides a structure that has effect on the behaviour of its members. These structures can mould the individuals who are born into the institution and at the same time the institution can be changed by the actions of the individual. There can be difficulty with the complexity and extensiveness when an

\textsuperscript{7} Ethical theory concerned with duties and rights
individual needs to make a decision faced with large amounts of information. Simple rules can reduce the complexity or the extent of choices available to a manageable model which has served the individual in the past leading to an optimal decision (Hodgson 1997).

Business organizations that contract with others, including suppliers, customers and employees may resort to the courts to uphold terms of a contract. In this way the institution of the judicial system supports the business institution, without which, order could rapidly disappear. The judicial institution cannot enforce its moral or physical authority without other institutional branches of the government such as the security forces. The security forces, particularly the police, could not operate without the implicit consent of the community – an agreed society.

Institutions are greatly influenced by their history. The evolution of the Irish health system is no different. Formal rules and traditions together with tacit knowledge shape the institutional environment. Many of the institutions that are in existence today owe their origins to customs which grew up in the culture of a country perhaps hundreds of years ago. For instance, the powerful role of doctors in today’s health system stems from two centuries of self-promotion of the profession from a time when they were less highly regarded (Barrington 1987). It is worth having a look at the role of path dependency in the formation of today’s institutions.

Path dependency is often seen as self-reinforcing feedback which causes institutional lock-in. Some of the cumbersome bureaucracy inherent in public institutions can be the result of path dependent maintenance of what Williamson (1993) refers to as ‘tosh’, that is superfluous rituals. Path dependence may create difficulties when the need for change arises. North (1991) argues that it is more than a simple evolution in which yesterday’s institutional framework provides the structure and context for today’s organizations. The dependent path is maintained by increasing returns creating the incentive for the formation of further organizations seeking profits.

The institutions we are mainly concerned with, in economic analysis, are the organizations of business, trade, government and the institutions that support them such as language, money and the law. The way organizations operate today owes a lot to the path dependency and the opportunities provided by the original institutional framework (North 1991). Much of the business organizations and
government institutions that are present today have their origins in the earlier institutions that in turn emerged from the embedded thought patterns, habits and rules of an earlier time.

Institutions matter in understanding the varying levels of performance in different economies (Aoki 2006). The contrasting economic history and continuing present day performance of North and South America are in North’s (1991) view due to the ‘pervasive influence of path dependence’. North (1991) traces the evolution of the New World colonies and their institutions contrasting the English and Dutch on the one hand and the Spanish and Portuguese on the other. The English colonization occurred at a time when there was an ongoing struggle between the monarchy and the parliament and religious and political diversity was becoming more widespread. In Spain at the same time the power of the monarchy was becoming more concentrated and political and religious diversity were non-existent. The subsequent development of North and South America followed the path set down in the mother countries. In the north there was a tendency towards local political control and entrepreneurial activity. Wealth-maximizing behaviour in the south focused on gaining control of the centralized bureaucracy (North 1991). These institutional positions remained after independence from the mother countries. These embedded tendencies are clearly observable to this day. At a the micro level attempts at institutional change try the difficult task of diverting the path and the performance of the new entity may not live up to expectation.

Institutions can be viewed in two different ways. The first is that rules were formed in a hierarchical order, exogenously determined, that is, outside the domain of economic transactions. These rules would be legal rules and social norms. The second is that institutions sprang up spontaneously, endogenously, by repeated operational plays of the game – game theory with an equilibrium outcome (Aoki 2006). Institutions evolve and change over time. What are the factors which motivate and shape institutional change? What are the factors that determine whether attempted institutional changes succeed or fail or whether new institutions persist or cease to exist? The following sections examine the question of institutional change and present a framework for understanding the drivers of change and institutional performance.
2.7 Institutions and institutional change

In Chapter 3 we examine two separate cases of institutional arrangements that were designed as models of mixed delivery for the Irish health services sector. In order to examine the history and outcomes of both cases it is necessary to illuminate the complex nature of institutional change in terms of its drivers, motivations and performance.

2.7.1 Why Do Institutions Change?

The cases examined in Chapter 3 had markedly different histories in terms of motivations for change and institutional performance. The cases of institutional change analysed are (1) the attempt to build private hospitals co-located with public hospitals in order to free up greater bed spaces for public patients by diverting private patients out of the public hospitals and into the private and (2) the establishment of the NTPF as method resolving long waiting times endured by public patients for medical and surgical treatment, by diverting them into the private sector. The co-located hospitals never reached the procurement stage for a number of reasons including risk transfer, a poor business model, lack of private health insurance backing and ultimately inability to fund the ventures. The NTPF addressed its brief and secured some success but gave rise to a number of perverse incentives with negative consequences and ultimately became politically and socially unacceptable.

Institutional constraints can be formal or informal. Informal constraints are constantly changing as society develops. Formal constraints i.e. the institutional environment, are contained in laws and property rights. Changes in formal constraints are effected by deliberate acts sometimes prompted by substantial movement in informal constraints over time. Institutions exist and function where the actors involved follow the rules and are positively served by it. Institutional change can be prompted by the necessary and unavoidable interaction between political and economic organizations. Both sets of organizations impact on each other. Individuals who are part of these organizations may drive change when they see a potential for an improvement in the position of their domain. Cultural change, as a necessary prerequisite for institutional change, may seep from one jurisdiction to
another, particularly where there is an existing degree of common culture. Institutional change demanded by individual actors may be motivated by the belief that their interest is no longer being fully served by the existing position, or because new ideas or new technology has presented a vision of a superior situation. These actors may become institutional entrepreneurs where they seek to adopt ideas from other cultures and other sectors and apply them to improve their sector (Groenewegen and De Jong 2008). While these factors are among the many possible sources of institutional change it is well recognised that change is embedded in an environment characterized by the interaction of political, social and economic factors. Embeddedness leads to culturally distinct configurations that require normative, cultural and political explanations of institutional arrangements (Schmitter, 1997:312, quoted in Saleth and Dinar 2004: 32).

### 2.7.2 A Framework for Understanding Institutional Change and Performance

To gain a deeper understanding of the nature of specific institutional changes in the Irish health services sector it is necessary to adopt a framework that recognises the complexity of institutional change in terms of the linkages between the wider institutional environment (the rules that establish the basis for production and exchange), governance structures (political and economic organisations) and individual decision makers. One such framework is offered by Saleth and Dinar (2004) who adopt a Three Layer Schema (see Figure 2.3) which is a synthesis of a similar schema by Williamson (1993) with elements from Eggertsson (1996). The schema is based on the principal elements of New Institutional Economics (NIE) including Transaction Cost Economics (TCE), embeddedness, path dependency and property rights and posits that change originates from the interaction of the institutional environment, the political and economic organizations and their governance structure, and individuals. It puts governance as the object of analysis but it does not exist in isolation. TCE, in particular, is relevant to institutional change. We employ this framework to illustrate what occurred in our cases.

Market-based theories of exchange and selection through competition may explain institutional change as seen through the Williamson lens. Institutional evolution in business is likely to come about due to the search for efficiency in delivering profits.
But institutional change involving government often comes about because of decisions arrived at by the interaction of political and economic organizations which may not be efficient in the way it serves the community as a whole. Indeed, institutions put in place by these decisions may persist for long periods of time because they suit the interests of those who have the power to change or block change. Some institutions came into being because of cultural or religious convictions prevalent at a particular time and persist long after their optimum usefulness has past. Institutional change may also come about because of the emergence of social conventions over time.

Institutions, causes of change and the resulting economic performance are all connected in a complicated relationships depicted in the Three Layer Schema. The top layer represents the institutional environment. That is the culture and setting within a state or other unit of political governance, the stock of institutions and the potential for institutional change.

The second layer represents the governance structure, or institutional arrangements, with the inevitable linkage between the economic and political organizations. Political organizations encompass the mechanism of government, including the elected politicians, both active in the executive and involved in parliament including opposition and the ‘permanent’ government – the civil and public service. The economic organizations are businesses and representative bodies who may lobby on their behalf. Within the middle layer where the governance structure is located the elected representatives owe their positions to the people who vote for them. So we have at this level, voters, elected politicians, permanent civil servants, owners and managers of businesses and a variety of lobbyists connected to all these groups.

The bottom layer represents individuals as ‘agents of change’ who are affected by their endogenous preferences, that is, individuals’ internal responses to external influences, including education, advertising, technology and social institutions which may determine economic outcomes. These preferences are also affected by the social, economic and legal structure of the institutional environment on the top layer. The behavioural attributes of the individual decision makers will also affect the way in which they interact with the governance structure on the middle layer. Institutional change comes from the dynamic interaction between the three layers.
Actual institutional change comes through political organizations – government and the bureaucratic structure. Government decisions are subject to influence from economic organizations which may be guided by shifts in the pattern of trade, advances in technology and changes in attitude due to the influence new ideas. Government decisions have an economic impact and the actions of economic organizations affect government so the interaction between these two sets of organizations tends to be close.

The institutional environment defines the rules of the game and is the focus of change. Some shifts may originate with the underlying assumptions of the individuals whose behaviour feeds into governance and affects the cost of governance. The main effects of the schema are shown by the solid arrows. The principal activity is the triangular relationship between economic organizations, political organizations and the institutional environment. Changes to the environment or the thinking of the individuals may lead to changed transaction costs. Feedback effects are shown by dashed arrows. These are refinements to the main causal relations depicted by the solid arrows. Strategic feedback from governance to the institutional environment may include changes in laws which improve contracting or uphold property rights and could also involve changes in government regulation which affects the course of trade or advances in technology.

Feedback from governance to the individual or ‘endogenous preferences’ refers to advertising or education in its various forms which affect the formation of an individual’s behavioural assumptions. These endogenous preferences can also be a product of the environment in which the individual lives and so that environment feeds back to the individual. The dynamic interaction between the three parts gives rise to institutional change.
Figure 2.3: Three Layer Schema of Institutional Change

The framework is embedded in social cultural and political and economic systems. Path dependency must be recognised in the context of using the private sector (historically) providing health services. The position of influence exercised by the medical profession owes a lot to the development of their power position over two centuries. Indeed the role of other individuals and groups, including politicians, civil servants, and others who wish to gain power or maintain it must also be taken into consideration. Transaction costs are the definitive issue in the judgment of whether to shift the balance between public and private influence in the health service and this cannot be isolated from the issue of risk as a governance issue.

Economic and political organizations play different roles in the process of institutional change. Economic organizations tend to exert their influence through support or otherwise for political organizations. Changes in trade conditions, new technology and other exogenous influences can prompt economic organizations to
encourage political organizations to make changes to the institutional environment. Decisions taken by political organizations have a major impact on the performance of economic organizations and the same is true in reverse and therefore there is bound to be a close relationship between these two sets of organizations. They both affect and are affected by the institutional change as they are part of the institutional environment. This is depicted in the schema with the triangular arrows. Other elements to this process are shift parameters and strategic transactions.

Individuals are the prime movers of change, whether by deliberate, strategic action or a gradual shift in attitude over time. Individuals influence change mostly through political and economic organizations. Not explicitly captured in the schema is the influence of other agents of change, such as media, popular culture, street culture, music, writers, academics, religious leaders and fashion (Galbraith 1958). It could be said that many of these other influences find their way into the system as part of the endogenous preferences in the schema.

The cost of exchange and production and thus the performance of the economy are affected by institutions. They determine the transaction (exchange) and transformation (production) costs which are part of the overall costs (North 1990, page 5 - 6). Change is not always in the direction of greater efficiency or purely for rent-seeking benefit as indicated by the ‘strategic transactions’. Many institutions have evolved over time and developed an incentive path which locks them in to a less efficient model. Indeed this is where the issue of power comes in. The continuous change in power relationship is a source of institutional change as those who have the power to make rule changes may be under the influence of many of the issues mentioned above. The issue of power is not directly captured in the schema but is assumed in that the rule makers (political organizations) exercise the power of change but also have the constraints of political office in a democracy. Power, the power to alter property rights, is not always exercised in an even-handed way. Those who have power strongly wish to maintain power relationships by strengthening their property rights.

Property rights involve transactions and simple spot-market transactions can be carried out without difficulty. Once greater complexity enters a transaction, the terms and conditions of the transaction need to be specified in the form of a contract. In
agreeing terms, parties to a contract will be aware of the level of risk they are facing. There is a proportionate relationship between risk and return. The party taking the greater risk will wish for the greater return as risk brings with it extra costs. Therefore contracts need to be crafted in a way that reduces potential risk. Creating new or changed institutions carries even greater risk as even the most detailed contract cannot envisage the unknown eventualities which may occur when the institution develops (Walsh 1995). Incomplete contracts, monitoring and their potential remedy in the law courts represent another cause of transaction costs. Hodge (2004) draws a distinction between commercial risk and governance risk and in that mix we could also include political risk (Johnson and Gudergan 2007). The consideration of risk is therefore a central issue in the governance structure and indeed risk is an underlying theme in all the sections of the framework.

The institutional framework acknowledges certain solutions that deliver ‘sub-optimal’ results even though institutional arrangements tend to form in ways which minimize transaction costs. However there are multiple equilibria to be balanced in order to arrive at the optimal institutional solution. There may be the consideration of the financial efficiency, allocative efficiency, equity and political feasibility. If any of a number of components is unbalanced the institution may be considered ‘sub-optimal’ in some respect. In a democratic system it is important that proposed changes are politically possible. There is little point in propositions which have no chance of legal sanction or practical implementation. Attempts to solve these different and often competing elements may not lead to a fully socially efficient institution. Institutions which range from those that are less than perfect to the downright perverse may continue to exist over long periods because they work satisfactorily for those actors who have the bargaining power to create and maintain the rules (Saleth and Dinar 2004). They may persist because the cost of change is greater than the perceived benefit. Therefore it cannot be said that reform or change will necessarily make improvements. The reformed institution may end up worse.

Disapproval of new developments in government may be opposed and obstructed by those who believe that their power base is being eroded. Institutional change is shaped by a multi-dimensional mix of influences encompassing the need for benefits to exceed costs within the existing institutional environment, social relationships as
they affect business and political decisions, path dependency, asset specificity and the variety of societal, economic and sectional interests which may or may not result in the optimal outcome.

The cases we present in this thesis can be explained in terms of different theories much of which are under a general heading of institutional economics. Public choice theory gives us a framework to place the exercise of political power and the struggles to either change or maintain institutions. These changes will result in altered property rights because of modifications in ownership. The changes ought to move in a direction which minimizes transaction costs. We have defined institutions and described the role of path dependence – how historical developments directly affect the culture of economic and social institutions of today.

Most of all we need to understand what are the motivating factors which give rise to institutional change. The Three Layer Schema incorporates many of the theoretic themes on which we can hang the issues of mixed delivery in health discussed in Chapter 3. The institutions we describe are present within the top layer where the stock of institutions is located together as part of the institutional environment which includes the law, culture and societal norms of the time. This environment contains within it the potential for institutional change as societal norms, culture and law develop. In the case of the NTPF, waiting lists became a political issue constantly being highlighted in the media as an unsolved problem. This fed the endogenous preferences of individuals, in the bottom layer, to become ‘agents of change’, in government to solve the problem and from lobbyists on behalf of the private hospital sector to enhance its position. This is where the interaction of political and economic organizations, in the middle layer, engaged to bring into being the agency which would fulfil their intentions.

A similar pattern can be seen in the case of the co-located hospitals project. The endogenous preferences were influenced by developments in Australia. Developers and members of the medical profession proposed to government the potential gains by increasing the bed capacity in the system and a willing government backed the proposal. In this case the part of the ‘political organization’, which was the civil service, blocked the progression of the project helped by some active politicians who
were opposed and by path dependency which favours the status quo. The detail of how the schema explains the issues in these cases can be seen in Chapter 3.

2.8 Conclusion

This chapter builds the theoretical frames we will use in the remainder of the thesis. The theoretical framework which guides the research draws on different strands of literature all of which address the question of the relative performance of public versus private ownership and performance. Public choice theory suggests that public organizations are less efficient than private ones because of lack of competition and soft budget constraints. Property rights are well defined in a private organization whereas they are diffused in a public one and this can lead to less incentive to monitor management behaviour or ‘principal – agent’ problems, i.e. the problem of ensuring that the agent (manager) is incentivized to pursue the same objectives as the principal (owner/shareholder/taxpayer). The insights of perspectives offer a number of research questions that this thesis aims to explore. Moreover the theoretical literature identified provides a well-established context for understanding findings and guiding the research.

We move now from theory to two case studies describing how ownership in health services has changed in Ireland: Hospital co-location and the National Treatment Purchase Fund.
Chapter 3:

Creating Mixed Delivery in Health Services: Two Cases – The Hospital Co-location Initiative and the National Treatment Purchase Fund

3.1 Introduction

Since the late 1970s governments around the world have looked to the private sector as a source of finance and management expertise to fill gaps in an expanding portfolio of public services. This chapter examines two cases where attempts were made to introduce the private sector into aspects of Irish public health delivery which had previously been the preserve of the public sector. These cases of institutional change in the Irish health services sector had markedly different histories. The first case was the initiative to allow private hospital developers to build hospitals on the campuses of existing public hospitals. This hospital co-location project (HCL) which was introduced in 2005 encountered a host of obstacles before its cancellation in 2011. The second case is the National Treatment Purchase Fund (NTPF) which was set up to purchase treatment in the private sector for public patients who had been on waiting lists for a fixed period. The NTPF was introduced in 2002 and operated for 9 years before it was scaled down in July 2011. The objective of this chapter is to examine these two cases of institutional change in the Irish health services sector and to examine the institutional constraints (social, economic and political) that shaped the history of both cases.

The framework for analysis is based on a stylized schema adapted from Williamson (1993) and Eggertsson (1996) which depicts institutional change as originating from the dynamics of interactions between (a) the institutional environment, (b) institutional arrangements of governance structure (the combination of economic and political organizations), and (c) individual decision makers. Data are drawn from the extant literature on the PPP experience in Ireland and semi-structured interviews with key players (politicians, government officials, private sector operators).
Use was also made of the Freedom of Information Act to access a copy of the Project Agreement for the co-located hospitals. Our thesis specifically seeks to answer the following questions:
• What are the key factors (economic, political, social and other) that motivated institutional change in the cases of (a) the hospital co-location project and (b) the national treatment purchase fund?

• What institutional factors explain the success (or lack of success) of both cases in terms of the implementation of the institutional change and the survival of institutional arrangements established?

The approach adopted in this chapter is as follows: First, both cases of institutional change are described in terms of their rationale, implementation and performance (where relevant). This follows the approach adopted in similar analysis of institutional change (Groenewegen and De Jong 2008, Saleth and Dinar 2004, Williamson 1975, North 1990). This is followed by a comparative analysis of both cases in terms of key concepts drawn from institutional economics and uses these concepts as a way of understanding how the issues unfolded the way they did.

3.2 Case 1: Hospital Co-location: A public-private partnerships for the procurement of hospitals

In June 2005 the Irish Department of Health circulated new guidelines on the development of private hospitals on the grounds of public hospitals. Seven sites were originally identified. The co-location concept had been developed with some success in Australia (Brown and Barnett 2004). The idea had been put forward by doctors and market research had been carried out to test the viability of the proposal. When testing the market several private property developers were consulted and expressed an interest in getting involved. Importantly, the political climate was favourable as Mary Harney, the leader of the Progressive Democrats, a pro-market liberal party, was Minister or Health and a strong advocate of the co-location proposal.

The HCP project was characterised by a number of the features of public-private partnerships (PPP) which, in the 1990s, came into vogue in a number of countries including Ireland. Such PPP models are typically characterised by long term contractual agreements between the public and private sectors. Under the terms of

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8 Interview with hospital CEO, 2010
the contract the private sector can undertake to design, build, operate and finance the infrastructure for an extended period (e.g. 20-30 years). Although the precise functions to be undertaken by the private sector differs from case to case, the PPP model invariably involves significantly greater private sector participation in public service delivery compared to traditional models (Hodge and Greve 2007).

Although independent and reliable analysis of the PPP experience in Ireland has been scarce there is evidence to suggest that the procurement of PPP projects has been more efficient in some sectors (e.g. roads, schools, courts services) compared to others (e.g. health and social housing) (Reeves 2013). This raises questions about the factors that determine the successful procurement or otherwise of PPP projects. To examine these questions we adopt an institutional perspective which draws on the concepts of transaction costs (Williamson 1975), property rights (Eggertsson 1996), risk (Johnson and Gudergan 2007), embeddedness (Granovetter 1985), asset specificity (Joskow 1988, Klein 2009, Brown and Potoski 2005, Reeves 2008) and interest group power (Moe 2005).

3.2.1 Rationale for Co-location Hospitals

The co-location policy was sold to the public as a simple way to create more public capacity by moving private patients out of public hospitals and into adjoining private facilities (Houses of the Oireachtas 2006). The total amount of beds in public hospitals was 11,500 and 20 per cent of these were designated for private patients (PA Consulting Group 2007). However the level of private admissions to public hospital for elective procedures can be far greater than 20 per cent. This means that at any given time a large number of public beds are taken up by privately insured patients. This in turn impacts on the ability of public patients to access public hospital beds and exacerbates waiting lists.

In July 2005 the Secretary General of the Department of Health and Children set out the rationale for the new policy in a letter to the chairperson of the HSE. First, the Finance Bill of the previous year provided for capital allowances over a seven year period for the building of private hospitals provided they met certain criteria. Second, it was official Government policy that:
“A significant proportion of additional capacity in the acute hospital system will be supplied in future by private providers. Government policy will aim to incentivise and attract private providers to develop private facilities, thereby freeing up capacity in public hospitals to treat public patients. The public sector will also procure a greater degree of services from the private sector” (Secretary General DOHC 2005).

The Minister for Health and Children was of the view that this offered a practical and relatively inexpensive method of providing significant additional capacity for public patients and the Department were determined to encourage the private sector and maximize the potential use of public hospital sites. Management consultants were commissioned by the DOHC to provide appraisal and criteria to encourage private investment. The HSE were instructed to undertake an immediate review of its estate portfolio in order to identify where private facilities might be located and they should seek expressions of interest from the private sector in respect of these sites (Secretary General DOHC 2005).

The rationale from the point of view of the private sector was that they were being presented with a good deal of encouragement to be involved in a process which was thought to have been successful elsewhere. The groups who were the successful bidders at the tender stage emphasized the positive effects on the public system which would flow from the development. Public sector hospital managers had no difficulty with following government policy. Additional bed capacity would be accompanied by extra operating theatres, radiology, ‘state-of-the-art’ ICT systems and financial management systems. This aspect was attractive to the management of the existing public hospitals:

‘….when it came to selection we were interested in the costing model, we were interested in the infrastructure they brought on to the site, the new opportunities it gave to improve the campus but also what we could gain from them in terms of patient management, hospital management, finance and IT systems as well, you know we could piggy-back on some of this stuff’ (interview with public hospital CEO, 2010).

The private hospital would also be prepared to invest in equipment or other infrastructure if there was seen to be a deficit in the public hospital. The co-located hospitals were also obliged to accept all privately insured patients no matter how they were admitted, including through Accident and Emergency (A&E). The
contract allowed for fines and possible termination and eviction of the private partner in the event that it breached the terms of the agreement.

3.2.2 Details of the Procurement Process

The co-location programme was the first public procurement process in Ireland to be negotiated using the Competitive Dialogue process. This was a new procurement procedure introduced for public sector contracts in an EU Directive (2004/18/EC). The rationale behind this procedure was that most PPPs were too complex to use traditional methods of tendering –

"where the contracting authorities:

– are not objectively able to define the technical means and/or capable of satisfying their needs or objectives and/or

– are not objectively able to specify the legal and/or financial make-up of a project." (European Commission 2005)

The Competitive Dialogue process commences with an announcement by the authorities that it requires the supply of certain goods or services. Dialogue is commenced with a minimum of three potential suppliers/bidders who are seen to have the financial and technical ability to identify and define solutions for the authorities. The bidder who can demonstrate the greatest economic advantage is appointed to ‘preferred bidder’ status. Dialogue with potential bidders is progressed in continuous steps and this dialogue should relate to technical, economic and legal aspects of the proposed project. The legal aspect specifically encompasses the distribution and limitation of risks, guarantees, and the possible creation of special purpose vehicles to advance the project. Proposals have to be submitted in writing to allow the authorities to make choices and reduce the number of bidders. At the appropriate time the awarding authority declares the dialogue concluded and calls for ‘final tenders’ to be submitted. There is explicit allowance for post-tender negotiations (OGC 2006) but once the preferred bidder is chosen the extent of post-tender negotiation is confined to fine-tuning their proposals and supplying additional information provided that the basic features of the tender are not altered. The fine-tuning is concerned with clarification and confirmation of commitments but

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9 Interviews with Preferred Bidders

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specifically excluded anything which would alter the price or the risk allocation after the ‘preferred bidders’ were appointed (European Commission 2005).

Preferred bidders were selected for four co-location projects. The Beacon Medical Group was chosen as the preferred bidder for the projects in Beaumont Hospital in Dublin, Cork University Hospital and the Limerick Regional Hospital while Synchrony Healthcare was the preferred bidder for the project at St James’s Hospital in Dublin. Project agreements were signed and planning permission was sought and granted for these four projects.

These projects never progressed beyond this stage. The successful ‘preferred bidders’ appeared to be misinformed about the correct operation of the Competitive Dialogue process and in interview with the author appeared to believe that they could re-negotiate aspects relating to the level of risk transference after the agreements were signed. This would have been impossible because the unsuccessful under-bidders would have taken legal action to prevent it. In the event no re-negotiation took place and they were unable to raise the funds for the project in the international banking market. The project agreements in each case expired at the end of March 2011.

3.2.3 Reason for failure 1: Transfer of risk
Having interviewed the CEOs of the ‘preferred bidders’ and ‘under-bidders’ some reasons emerge as to why the implementation of this institutional change did not succeed. First, the contracts ran into trouble on the issue of risk transference. The Beacon Medical Group (BMG) claimed that if the private partner could not complete its side of the project then the state would have the right to confiscate the asset but should be obliged to compensate the partner up to the extent of their borrowings. The Minister for Health, Mary Harney, claimed that to do that would be to provide a guarantee which would allow the private partner to avoid their proper portion of the risk:

‘A core principle underlying the co-location initiative is that the private sector should bear all normal business risks. It is a matter for each successful bidder to arrange its finance under the terms of the relevant project agreement. The co-location initiative, like other major projects, must deal with the changed funding environment’ (Harney 2010).
This was the so-called ‘termination without compensation’ clause\textsuperscript{10}. The preferred bidders claim that they and their potential financiers believed that they were taking on an unsustainable risk whereby opportunistic behaviour could be exercised with relative ease resulting in the complete loss of all of their investment without compensation. An organized group, such as a trade union, could engineer a hold-up which could damage the private business to the point of its viability. It has been claimed by one of the bidders, in interview with the author, that the issue of risk transfer was pertinent for the government at the time the project agreement was being drafted because the government was engaged in a costly buy-back of the M50, a toll road surrounding Dublin, from the private operators who had been running it since it was built in 1990. However it must be noted that ‘termination without compensation’ has been a standard clause in PPP agreements involving road building since the inception of the original PFIIs in the UK in the early 1990s according to the legal author of the project agreement (interview with author). In addition some of the bidders were already running private hospitals on their own sites far removed from public hospitals which were financed as ‘stand-alone’ operations. Therefore it was open to question as to why they were seeking the risk protection of compensation in the event of the failure of the co-location project.

The successful bidders, BMG and Synchrony Healthcare both claim that they signed the project agreements and became ‘preferred bidders’ on the understanding from the HSE that the clause could be amended at a later stage. This claim is difficult to square with the EU Commission guidelines which excludes any alteration of risk allocation after the agreement has been signed. As it stood financing the projects was proving difficult. At this stage other bidders were excluded by reason of an unsuccessful bid or having voluntarily withdrawn due to financing difficulties. Some of the bidders believed that the project was not viable at this point and set their bids accordingly\textsuperscript{11}. The preferred bidders were confident that once planning permission was granted for building on the sites, the agreements would be modified to allow for greater comfort for the financiers in the event of future difficulties of the operators.

\textsuperscript{10} The Project Agreement Clause 28.6 Consequences of Termination for Private Partner Default ‘Where the Public Partner terminates this Agreement under Clause 28 (Termination for Private Partner Default) the Private Partner shall not be entitled to any reimbursement or compensation (whatsoever) in respect of such termination.’

\textsuperscript{11} Author’s interview with ‘under-bidder’
When planning permission was in place the preferred bidders claim they were informed by the HSE that they would need evidence that banks had refused to advance funds for the project before there could be any question of altering the contract. This represented a significant amount of uncertainty for the operator and resulted in prolonged negotiations which ultimately proved fruitless.

3.2.4 **Reason for failure 2: Private Insurance Cover**
A further complication for the successful bidders at this time was that the Voluntary Health Insurance Company (VHI), the state-owned health insurance company, stated that they would not cover their clients in the co-location hospitals claiming that there was already sufficient, if not surplus, private hospital capacity in the country. The problem for the VHI was that 50 per cent of the population are covered by private insurance and the VHI had a market share of 80 per cent, so any increase in private capacity would result in a greater claims pay out for the insurance companies with little prospect of any increase in premium or market share. At that time it was also facing regulatory difficulties with the EU which required a large injection of government funds. Overall, any expansion of capacity in the private health sector may result in greater financial pressure on the VHI. Its best option was to maintain or reduce the level of activity and they were in a position to influence this by refusing to cover new entrants to the market.

3.2.5 **Reason for failure 3: A Poor Business Model**
Other bidders have suggested that although the ‘termination without compensation’ and the VHI are two easily understood issues there were also grave doubts about the revenue model for the business. There was, for example, no guarantee that privately insured patients would transfer to the co-located hospital and there was nothing to compel them to do so as all citizens are entitled to free care in the public sector. Despite the existence of Service Level Agreements between the two sectors, public sector doctors may wish to keep patients under their care whether or not the patient also has private health insurance. Under current funding arrangements public hospitals depend on the income from private patients to supplement their budgets. The private sector was required to take ‘demand risk’ in a situation where doctors in the public sector had the power to divert their potential ‘customer’ back to the public side of the hospital. This represented another issue in which, difficult to detect, hold-ups could undermine the operation of the private side of the co-location project.
Even if this problem could have been overcome it would have added the extra transaction costs of constant monitoring.

3.2.6 **Reason for Failure 4: Public Sector Opposition**

The preferred bidders who were interviewed by the author strongly believed the project had support at political level but suggest that officials in the Department of Health and the HSE were dragging their feet on fixing the contracts to make it bankable. There was the perception that some of the negotiators on behalf of the HSE were not receiving fulsome support from the civil service and many of the technical aspects of the project had not been thought through from the government side.

After due process, planning permission was granted for the four sites. By August 2010 BMG had spent €30 million on co-location between tendering costs, analysis, research and planning permissions and claimed to be ‘shovel ready’ to start building their first project – the Limerick Regional Hospital unit. But by that stage the financial recession was well entrenched, finance for the project was not in place and political sentiment was moving against it. In the general election of February 2011 the incumbent government was heavily defeated and a new government which included the centre-left Labour Party came to power. The project agreements expired at end March 2011 when time allowed for the preferred bidders to secure funds had passed. Neither of the preferred bidders was able to fund the project within the specified time and all discussions with the HSE ceased (C & AG 2011).

3.3 **Case 2: The National Treatment Purchase Fund**

The second case of institutional change which we examine is the National Treatment Purchase Fund (NTPF) which was introduced to reduce hospital waiting lists by means of employing the private sector. The NTPF was unique. Many health systems internationally have waiting list management initiatives but none had a separate agency devoted to the problem.
3.3.1 Hospital Waiting Lists – A Global Phenomenon

All over the world in a variety of different health care systems there are waiting lists. These are groups of people who require medical or surgical treatment but must wait until the appropriate clinicians or facilities become available. Waiting lists, like poverty, appear to be always with us. However demand for health care, unlike other markets, is not generally determined by price. Rather, waiting time may act as a substitute for the price mechanism as a system of rationing health resources. Forcing down waiting times may be equivalent to price reduction and can give rise to increased demand (Sivey 2009). This, coupled with continuous development in medical technical innovation may mean that efforts to solve the problem can never be fully successful without the diversion of huge resources from the rest of the economy sometimes referred to as the ‘health spending Black Hole’ (Wren 2004). In ‘priceless’ universally accessible systems there will always be waiting times but those who have the financial resources will be able to opt out of queues by paying for treatment, in another jurisdiction if necessary (Rajsic 2010). Waiting lists develop when the demand for a service exceeds the supply at any given time. International experience suggests that initiatives to solve the problem have been less than successful. The problem may lie in the institutional structure of organizations in the health sector and solutions which have been tried have been based on unrealistic assumptions about the behaviour of these organizations. Kenis (2006, p.295) lists four propositions as to why these initiatives do not work:

1. Extra resources do not necessarily reduce waiting lists.
2. Counting and publishing the numbers on the lists contributes nothing but produces a number of unintended negative consequences.
3. Not every party connected to the problem has an interest in reducing the lists.
4. It is important to manage the organizational interdependencies in the system

Waiting lists are not necessarily caused by lack of money but are more complex and reflect the inter-reliance in the system. This was exemplified in the Waiting List Initiative (WLI) in Ireland in the early 1990s where extra funding did little to solve the problem (see below). Counting the numbers on waiting lists gives an indication
of the size of the problem. However, long waiting lists for certain types of treatment may deter doctors from referring patients for treatment which might be optimal. Also the more the problem is addressed by extra specialists, for example, the more demand is created and a new equilibrium is reached (Summerhurst and Williams 2001). Other potential negative consequences might include costs, strategic behaviour, false security and misuse of information (Kenis 2006).

3.3.2 NTPF – Description
In Ireland, The NTPF was set up as an agency within government to organize private treatment for public patients who had been on a public waiting list for a specified time. The official mission statement of the NTPF established in 2002 put it thus:

‘The National Treatment Purchase Fund is an independent statutory agency established by Government with the primary aim of providing faster treatment for public patients. The mission of the NTPF is to reduce the amount of time public patients are on hospital waiting lists for surgery by offering choice in obtaining ACCESS TO TREATMENT promptly, safely and to a high standard of patient satisfaction.’ (NTPF 2009)

Prior to that there had been The Waiting List Initiative (WLI) which was in place since 1993. The WLI involved the provision of extra funding by the Government, which would be ring-fenced, for this particular task. Its aim was to target particular areas where waiting lists were worst and apply the funds to free up resources and reduce lists (C & AG 2003). This was to be achieved by incentivizing hospitals and health boards to perform extra elective procedures. It was put in place as a short-term measure but continued year after year until the setting up of the NTPF. Funds provided under WLI were given to individual hospitals and those hospitals used the funds to pay for extra waiting list administration, bed management and the provision of temporary consultant posts many of which were subsequently made permanent.

As much of the funds went into payment for extra staff it was difficult to judge if the funds were effective in targeting the problem they were designed for as they got swallowed up in general funding. The Department of Health and Children (DOHC) set targets for the maximum time patients should wait for treatment. These maximum targets were 12 months for adults and 6 months for children. Between 1998 and 2002 the waiting time for those groups were reduced by 39 per cent but the reduction was not even over all specialities. Some waiting lists lengthened. Neither was the
improvement equally distributed geographically with the majority of patients still on long waiting lists by 2002 concentrated in the Eastern region. Even within that region some hospitals had no waiting lists while others had lists which were considerably above average.

3.3.3. Rationale for the National Treatment Purchase Fund
In 2001 new health strategy titled *Quality and Fairness*’ proposed a National Treatment Purchase Team that would commence discussions with hospitals and consultants to make arrangements to find capacity, both within Ireland or abroad, to get people who were on the waiting lists treated. Another issue which had to be addressed was the streamlining of the data on waiting times which had been chaotic up to this point. The NTPF was established as part of a number of initiatives designed to solve the problems of overcrowding and lengthy waiting times for a number of procedures. Other issues being addressed were the bed capacity in public hospitals, the quality of hospital management and accident and emergency services (DOHC 2001). The NTPF was supposed to be a short-term measure but it continued to purchase treatment on behalf of patients for nine years.

The NTPF was given the responsibility of collecting the national waiting lists data and by the end of 2004 (DOHC 2004) the Patient Treatment Register (PTR) was announced, a database of all waiting times managed by the NTPF. There is now a national register which is accessible to the public and is produced twice a year. In 2009 the NTPF was given the further responsibility of negotiating nursing home bed charges for the HSE as part of the Nursing Home Support Scheme Act, 2009. This is a scheme designed to provide financial support for people who require long-term residential care mainly for older people (Government of Ireland 2009). In 2009 prices were negotiated with over 400 private nursing homes.

The NTPF was promoted as a practical way of resolving a problem in the health services and as an organization it carried out its brief as it was intended. Opinion from medical practitioners and political and social commentators was, for the most part, negative. Although it was partially resolving problems, it was doing so at a high cost. The taxpayer was paying ‘on the double’ – funding the large public sector which could not cope with the demand and then also funding the private sector. The NTPF budget of over €100 million in 2008 went mostly to the private sector. It was
described as ‘an expensive sticking plaster’ (Hunter 2009, Culliton 2010, Burke 2009, O’Keefe 2010). It was seen as a prop for private hospitals and providing perverse incentives which many in the medical profession were increasingly embarrassed about. After the change of government in 2011 the NTPF role was altered. It was now up to hospitals to ensure that all patents were treated in a timely fashion. Only in cases where hospitals failed to do so did the NTPF have a role in procuring treatment. Further the stipulation that the NTPF purchase 90 per cent of treatments in the private sector was ended.

### 3.3.4 Key factors motivating the institutional changes

If the Irish Health system worked efficiently there would have been no need for the NTPF. If the NTPF conducted its work to the maximum efficiency it could have worked its way out of business. But this did not happen. Waiting lists are an imperfect way of measuring the efficiency of a system but any single metric can be addressed in isolation particularly if it has become recognized as a politically sensitive problem. A state agency purchasing services in the private sector was not new. Most of the infrastructure in the country was built by private firms fulfilling government or municipal contracts. Contracting surgical services to the fledgling private sector had not been done before and may have been viewed by some purely as an act in support of the private sector (Burke 2009).

The governments which ruled from 1997 to 2011 were a combination the traditional nationalist party, Fianna Fáil (FF) and the newer Progressive Democrats (PD), which was a pro-free market liberal political party. Although the latter was virtually wiped out in the 2007 General Election, the leader and Minister for Health, Mary Harney survived and continued as Minister until late 2010. The larger Fianna Fáil was itself a broad ideological coalition but many members were quite sympathetic to the more strident PD position. Therefore a lot of the PD agenda ended up as official government policy. This agenda included privatization, public-private partnerships and greater private sector involvement in all areas of government. The NTPF was introduced as a short-term measure but by the time the PD leader assumed the office of Minister for Health in 2005 it was a central platform of government health policy.
Waiting lists had become a political issue. While the country was experiencing an unprecedented economic boom it seemed incredible to many that basic issues involving the health and welfare of the citizens could not be addressed. Those in power were predisposed to the view that the inability to address these problems lay in the inflexibility and intractable nature of the public service. The potential solution to the problem appeared to lie in the private sector. A former junior health minister, in interview with the author, admitted that there was ideology involved but: ‘ideology if you like, but for the right reasons to look after the poor people’.

3.3.5 Performance of NTPF
The absence of hard metrics makes it difficult to conduct a thorough analysis of the performance of the NTPF. Where data are available in relation to dimensions of performance such as cost effectiveness the evidence tends to be favourable. However, a much wider set of issues around aspects such as the creation of perverse incentives and in using the private sector even though there was spare capacity in the public sector gave rise to the suggestion that the NTPF was an expensive duplication of services which delivered public money into the hands of private business people and consultant surgeons.

The nature of the activities of the NTPF and the lack of information in the public domain reduce the scope for a thorough analysis of the financial performance of the NTPF. Where data is available however, it indicates that when the NTPF is compared to other public health agencies it performs well in terms of cost control. In 2010 the NTPF received a budget of €90 million. This was the same budget as 2009 but down from €104 million in 2008. The level of administration costs has been stable over the same period, being 4.7 per cent (2010), 5.3 per cent (2009) and 4.5 per cent (2008) of the total budget\(^\text{12}\). While the limitations of making comparisons with other health agencies must be noted the available cost data (see Table 3.1) indicates that the NTPF was relatively efficient.

\(^{12}\) These are the figures supplied to the Committee of Public Accounts Debate on the National Treatment Purchase Fund, the NTPF Annual Report that administration expenses were 5 per cent (€4.5m) and the C&AG audit puts administration costs at €4m.
The NTPF negotiated a reduction of 8 per cent in fees with private hospitals in 2010 over 2009 (Committee of Public Accounts Debate 2011). Information on the exact prices for any procedure is a closely guarded secret within the NTPF and the private hospitals. They cite ‘commercial sensitivity’ as the reason for not disclosing this information. Equally, the VHI’s schedule of fees sets the charge for many procedures and is not available to public scrutiny.

Table 3.1: Other Health Agencies Audited by the C&AG

<table>
<thead>
<tr>
<th>Agency</th>
<th>Total Budget (€mil)</th>
<th>Staff Costs (€mil)</th>
<th>Number of Employees</th>
<th>Other Costs (€mil)</th>
<th>Cost per Employee</th>
<th>Administration Cost per Employee (€mil)</th>
<th>Staff Cost/Total Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Treatment Purchase Fund</td>
<td>90</td>
<td>2</td>
<td>46</td>
<td>2</td>
<td>43478</td>
<td>945.18</td>
<td>0.02</td>
</tr>
<tr>
<td>Food Safety Authority of Ireland</td>
<td>18</td>
<td>5.9</td>
<td>91</td>
<td>4</td>
<td>64835</td>
<td>712.47</td>
<td>0.33</td>
</tr>
<tr>
<td>Health Insurance Authority</td>
<td>2.6</td>
<td>0.68</td>
<td>9</td>
<td>0.82</td>
<td>75556</td>
<td>8395.06</td>
<td>0.26</td>
</tr>
<tr>
<td>Health Research Board</td>
<td>35.2</td>
<td>3.9</td>
<td>72</td>
<td>3.1</td>
<td>54167</td>
<td>752.31</td>
<td>0.11</td>
</tr>
<tr>
<td>Health Information and Quality Authority</td>
<td>13.9</td>
<td>9.6</td>
<td>173</td>
<td>4</td>
<td>55491</td>
<td>320.76</td>
<td>0.69</td>
</tr>
<tr>
<td>Irish Medicines Board</td>
<td>24</td>
<td>15.2</td>
<td>266</td>
<td>7.5</td>
<td>57143</td>
<td>214.82</td>
<td>0.63</td>
</tr>
<tr>
<td>Office of the Director of Tobacco Control</td>
<td>1.8</td>
<td>0.7</td>
<td>15</td>
<td>1.1</td>
<td>46667</td>
<td>3111.11</td>
<td>0.39</td>
</tr>
</tbody>
</table>

Sources: (Jordan 2011); (NTPF 2009); (Food Safety Authority of Ireland 2009); (Health Insurance Authority 2009); (Health Research Board 2009); (Irish Medicines Board 2008); (Office of Tobacco Control 2008)

The NTPF dealt with at least nineteen private hospitals so it could make valid comparisons between these when carrying on negotiations. It also had the potential to bring volume business to a private hospital whereby a greater discount can be granted. The NTPF benchmarked its prices against Casemix\(^\text{13}\) prices in public hospitals and was satisfied that it was competitive (Interview with NTPF CEO). The VHI customer experienced up to a 40 per cent increase in premium at the same time as the NTPF negotiated a price reduction this suggests that the NTPF patient was being treated for a lower price than the VHI patient (Committee of Public Accounts Debate 2011). Also, the additional work under the Homes Support Scheme Act was carried out in the context of the reduced budget. These factors suggest that this agency was well run and addressed its mandate in spite of the fact that its existence

\(^{13}\) Casemix Ireland allows for the collection, categorization and interpretation of hospital data to assist hospitals to measure their productivity and assess quality.
in the marketplace caused some distortions which led to a lot of popular and professional opposition.

3.3.6 Other aspects of performance and criticism
The NTPF also used public hospitals but were limited to refer no more than 10 per cent of its cases to public hospitals. The reason for the 10 per cent limit was to ensure that NTPF activity did not interfere with core hospital activity such as Accident and Emergency. In 2010 it referred 7 per cent of patients to public hospitals. It did this in cases where the complications were such that the personnel and facilities were not available in the private sector. Because of this the NTPF was accused of ‘cherry picking’. The ‘cherry picking’ criticism would be more appropriately aimed at the private sector rather than the NTPF. For some private hospitals to take such cases might be financially unviable and medically unsafe. The NTPF is sometimes seen as a support for the private hospital sector without which the sector might not survive.

This claim is denied by surgeons working in the private sector some of whom suggest that improvements in facilities mean they are often happier for their patients to be treated at the private facility rather than the public one (Interviews with author). Further, it has been suggested that certain public hospital managers are happy to let the complicated cases languish so that they will be picked up by the NTPF and have their treatment either in the private sector or the public sector but the treatment would be financed by the NTPF thereby either saving the hospital budget or adding to its income if the treatment was carried out in the same hospital. To avoid any accusation of collusion surgeons involved can swap patients so that it does not appear that they are simply moving patients into the NTPF for financial gain. This is a win – win – win situation in that the public hospital gains financially by savings in its budget. The surgeon who carries out the operation gets the private fee from the NTPF either in the public hospital or the private facility and the hospital carrying out the treatment, (again either public or private) gets its fees. The patient is treated successfully and the only loss is to the tax payer who is picking up the bill, twice.
This situation presented a set of perverse incentives which would not have existed without the NTPF being in the market. Other criticisms that may not be justifiable but they did add to the bad press. There has also been a suggestion that the NTPF simply dealt with a procedure and that aftercare or complications were ‘dumped’ back into the public sector (Houston 2006). This argument cannot be sustained as the NTPF negotiated fixed prices for set procedures on a ‘per episode’ basis with hospitals. This includes consultation before-hand, the procedure itself and any other care necessary afterwards. The hospitals are not paid until the entire episode has been completed (Committee of Public Accounts Debate 2011).

3.3.7 Professional Opinion
The NTPF appeared to be addressing its mandate but there were criticisms from the start, including from within the medical profession in spite of the fact that many doctors were benefiting from its activities. Certain patients on public waiting lists were treated through the NTPF in public hospitals. Critics of the agency say that it consumes large amounts of public money that could be better used within the public system. Michael O’Keefe, a consultant ophthalmic surgeon summed up the nature of the current system:

“I find it inexplicable that patients have treatments in private facilities, while public facilities staffed with doctors, nurses and porters who could treat these patients at no extra cost lie idle.

A striking example of this madness is that more cataract operations are performed on a Saturday in Dublin’s Eye and Ear Hospital than on all of the other five days of the week by the same medical and nursing staff” (O’Keefe 2010).

In gathering information for other sections we conducted sixteen interviews with consultant surgeons, three with General Practitioners (GPs) and three with hospital CEOs. As an aside from our general inquiries we asked for an opinion and experiences with the NTPF. There were mixed views as to how effective it was but the majority viewed it negatively. Even those who recognized that it had a job to do and did it would have been happier had it not existed:

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14 A number of health professionals, journalists and other commentators have made similar criticisms. Michael O’Keefe’s article is representative of many similar pieces.
‘I think that the NTPF provided a very good service but I always felt that it was unnecessary. It didn’t need to happen if the Government were prepared to address the deficiency…..’ (Surgeon SO7).

Others were less complimentary:

‘It was used as a Band-Aid for a system that was falling apart where it benefited private hospitals financially and then on the other side we didn’t have…..we were getting the patients that nobody else wanted to operate on and we were getting no suitable surgery to train our juniors on either you know but really it was just a business opportunity for vultures on the outside to come in to pick off the carcass of what was left of the HSE’ (Surgeon SO6).

This was an extreme reaction which sought to portray the NTPF as merely a conduit through which business was directed to the private sector. Having spoken to CEOs of private hospitals this cannot be said to be universally true. Some avoided getting too dependent on the NTPF as a source of referral:

[Business from the NTPF is] ‘absolutely insignificant because as I said our business model was based on broadening of the disciplines that we had and not the dependency on any one whereas I am aware of other private health care institutions that were highly dependent on the National Treatment Purchase Fund to their detriment’ (CEO 3).

Others who were open and adequate to get NTPF business complained that they were not getting the level of referrals that they might expect and believed that competing private hospitals were getting a greater proportion of the available referrals without an obvious explanation (CEO 1). The CEO of a large public hospital had no ideological difficulty with the concept but questioned whether or not we were getting the best value:

‘It creates the capacity to get waiting lists down and gets service for patients. Whether we are getting the best value, I haven’t seen any assessment of it. Are we getting the best value for the money on what’s being spent on the NTPF?’ (CEO 2)

A consistent complaint about the NTPF is that it treated the symptom rather than the cause. It was an instrument to silence those who chose waiting lists as the weapon of
criticism. In other parts of the world they can solve waiting list problems by simply not counting them. One surgeon demonstrated why the NTPF was not necessary in his area:

‘……we don’t have too many patients…………..who are eligible for NTPF because our waiting lists for surgery are low. But they are only low because we put the valve at an earlier stage in the process. So we don’t see hundreds of GP referrals to make our waiting lists longer – you wait longer to see us and health stats are focusing in on those figures’ (Surgeon S2)

In this area the consultants and the GPs manage the situation so that waiting lists are not artificially created. It is unknown how many people in the community may be suffering from disabilities which could be solved but they have yet to show up as being on a waiting list for surgery. In other areas some consultants have long waiting lists both for public and private work. It could be argued that this is unnecessary and creates a situation where there is great potential for people on the public list to become eligible for private treatment through the NTPF where the consultant or a colleague will reap the benefit of the private fee while still drawing a public salary for public work.

A number of surgeons expressed the view that if the money spent on the NTPF was put into the system waiting problems would be solved. However this was tried with the WLI. Others, predominately those with a significant private practice were more supportive:

‘Well my opinion, you can be ideological about it and say that it’s terrible that these people cannot be treated in the public hospital or be practical about it and say that it’s a wonderful service. I don’t think that many people could disagree that in the private sector we can do these procedures for a fraction of the cost and we can probably do three to four times the volume at least due to the restrictive practice in the public hospitals and I don’t think I’m being controversial there’ (Surgeon S04).

There was some evidence to suggest that public hospitals were shifting problem patients to the private sector via the NTPF as a cost saving measure referred to above:

‘When we were doing the NTPF initiative a lot of the patients who weren’t being operated on in the public hospital were transferred on to the NTPF list.
An ophthalmic surgeon suggested that if there were three major cataract specialist centres in Ireland where all cataract operations were done the efficiencies would solve the waiting list rapidly. However a study of waiting time and distance on hospital choice for English cataract patients (Sivey 2009) found that travel time had a much stronger effect on hospital choice than waiting time. This may account for the very high incidence of patients not showing up for their appointment after the NTPF has arranged faster treatment but in another more distant location (O'Regan 2011b).

### 3.3.8 Outcomes

In July 2011 the Minister for Health announced that the NTPF would cease routinely accepting referrals of patients waiting over three months and target particular backlogs. He also ended the requirement that the NTPF purchase 90 per cent of treatments in the private sector. All public hospitals were instructed to ensure that there were no patients waiting more than 12 months for treatment by the end of the year. Management of the waiting list problem is being undertaken directly by the Department of Health under a new body called the Special Delivery Unit (SDU). The criticisms of ‘cherry picking’, manipulation by managers and surgeons, blatant support for the private sector and treating the symptoms rather than the cause finally made it politically unacceptable.

The NTPF was a mechanism to direct funds specifically to resolve a difficulty which was identified as an on-going problem by professionals and gained notoriety among the public (voters). This view is given greater credence when the NTPF is contrasted to WLI where funds were supplied to achieve the same results but were invariably siphoned off to areas which were of most pressing need to the individual institutions at that particular time.

The NTPF produced more tangible results than the WLI. Over 200,000 patients were treated under the NTPF who might have otherwise swollen the ranks of the waiting
lists. Since 2002 the NTPF claims to have reduced wait times for treatment by between two and five months but this has been at the cost of €597 million to date.

3.4 Discussion

In Chapter 2 we outlined some of the theoretic background to institutions and institutional change. What are the key factors motivating the institutional changes in these cases and what institutional factors explain why persist, evolve or cease? These questions suggest other questions, such as: How do institutions perform? Who gains and who loses as a result of institutional change? What groups in society are the motivators for change? There are, in all societies, groups who seek greater power and influence as a default to avoid the possibility of the potential erosion of what power and influence they currently perceive themselves to possess. Equally there are gradual changes in the status of professions and groups which results in alterations in the level of influence that the group exerts. Groups like doctors, lawyers, politicians, businesspeople, the judiciary, the aristocracy, the Church (or churches) have all seen their strength ebb and flow over the centuries.

The changes which occur with the dynamic triangular interaction between the institutional environment, the economic organizations and the political organizations are assisted by shift parameters and strategic transactions which are represented on the schema by broken arrows going from institutional environment to institutional arrangements. Shift parameters are the changes that shift the cost of governance, that is, transaction costs.

The advent of the NTPF and the adoption of the HCP as government policy both came about as a result of lobbying by interest groups, owners of existing private hospitals and developers and medical professionals who wished to lock their private business into the public provision of services. Lobbyists were dealing with a willing government who saw the involvement of the private sector as an easy option to expand capacity in the system without adverse consequences for the public finances. They believed the NTPF would solve the waiting list problem and the HCP would add much-needed extra beds to the system. It was largely sold to the public as a
practical solution to a lack of capacity in the public sector. The effect of the NTPF was to bolster the fledgling and weak private hospital sector. It also created on the part of doctors and hospital managers the ability to move people from the public to the private sector and thereby create extra income. This activity could be described as rent-seeking behaviour and is represented on the schema as the strategic transactions which move from institutional arrangements to institutional environment. In the case of the HCP it was believed that moving private patients out of public hospitals would free up space but the backers of the proposal saw the potential of capturing all of the private market, both the out-of-pocket payers and fees provided by private health insurance.

The cultural change, in the form of the influence of pro-privatization and pro-market ideas and NPM seeped in from Britain, Australia and other countries. The rise of NPM has been described as: ‘the most striking international trends in public administration’ (Hood 1991). Both the NTPF and the HCP were a result of the influence of NPM which by that time had become a global phenomenon. This influenced politicians to seek private sector alternatives to public sector problems. Hood, links other trends to the rise of NPM, such as, attempts to slow down the growth of government, the drift towards privatization, quasi-privatization and the use of public-private partnerships together with the development of an international agenda seeking to standardize intergovernmental co-operation. To the last point we could add the influence of European Community regulation on how governments present their budgets. This is represented on the schema on the top layer where the institutional environment, in the form of culture, laws and regulation was changing and this change feeds (via the broken arrow of the schema to the bottom layer) back to individuals and their endogenous preferences, who then become agents of change.

For economic organizations the philosophies described above proved to be an opportune symbiosis. Private sector businesses had everything to gain as governments sought their assistance in providing public services. The interaction between government and business, which is at the heart of the framework, proved to be an easy relationship as these philosophies were embedded in the political system with the increasing popularity of pro-market-based-reform politicians. Into this mix
we have the prevalence of path dependence in that Ireland had a long history of mixed delivery for services.

In the case of the HCP there was an active and systematic attempt by business people, and doctors to create a revenue producing entity from activity which had previously been dominated by the public sector. These efforts were influenced by the fact that it was official government policy. Co-located hospitals had been seen to work in Australia. Business promoters and doctors looking to become medical entrepreneurs would have made considerable financial gains if this project had been fully developed. This would represent a shift in power away from forces within the public sector. These forces, in the form of senior civil servants in the Department of Health, knew well how to let an idea or an initiative wither on the vine.

Our interviews with the private sector participants suggest that the government negotiators were ill-prepared and not qualified for the task they were given and further, that they were hand-picked because of their lack of suitability. This issue caused a lot of hold-ups and frustration in the negotiations but represented a nuanced but deliberate fight-back by a group who wished to stymie the affair. This view was contested by a public hospital CEO who said that whatever personal views were originally held, once a policy became ‘the only game in town’ then public servants rowed in behind it.

The actions of the ‘blockers to change’ did not need to be overt or forceful as their opponent’s business model was far from perfect. The failure of the HCP promoters to establish a proper balance of risk between the two would-be partners made potential lenders reluctant to getting involved. This left the HCP promoters with an excuse, to be aired in public, that they had been treated unfairly and lost a considerable amount of money in sunk costs due to the connivance of powerful interests in the civil service. It appears this constellation of actors, comprising business interests, medical interests and some conviction politicians were no match for what some describe as the ‘permanent government’ – the civil service.

Better informed under-bidders suggested to the author that the business model was fatally flawed in any case. There was no guarantee that private patients would
migrate to the private hospital – there was nothing to force them. They were entitled to free care in the public hospital as a right and their physician may well suggest that they stay in the public system. Actions by any organized group, such as trade unions representing a small but crucial group within the public part of the co-located hospital could deal a deadly blow to the private hospital business. A trade union as a political organization could be moved by the actions of a few individuals opposed to the project. The view of this under-bidder is given greater credence by the fact that it has recently completed a successful co-location deal in another jurisdiction which addressed all the problems of risk transference and the source of business traffic. These influences by individuals are what Saleth and Dinar refer to as implicit and subjective and are channelled through the governance structure as distinct from the direct and objective influence of individuals as agents of change.

The case of the NTPF has less to do with a tussle over power and territory but did offer extra business to private operators. This business was diverted from the public sector. Its problem was that in solving one set of problems, the waiting lists, it created another – perverse incentives. It became clear to many, including those who were gaining benefit from its activities that it was a very expensive ‘band aid’ which contributed nothing to resolving systemic flaws in the public delivery of health services (Burke 2009).

The contribution being made to the study of public and private delivery of health services by examining these two cases is that we can see that implementation of new policies or the prevention of new policies is not an ideological or sectarian struggle but a power play for influence between groups who are already well placed in Irish society. These groups are within the governance structure of the framework. These groups, or organizations, are a representation of the collective interests of individuals who form these organizations. Individuals use their influence in a direct way or as part of a collective. The framework illustrates what happened and what could have potentially happened. For example the general election in February 2011 brought to government the Labour Party which was deeply opposed to the workings of the NTPF. That alteration at the heart of the governance structure made it clear the NTPF would be stopped from diverting funds to the private sector.
In the HCP external factors dramatically changed the institutional environment. The great financial crisis which swept through the world in 2008 causing a credit crunch put paid to the already slim chances of either of the preferred bidders getting finance for their projects. The framework cannot explain the misplaced belief that parts of the contract would be altered to rebalance the risk, after planning permission was granted for building. This was a major flaw on the part of the preferred bidders and can be demonstrated as an example of bounded rationality. It is all the more surprising as the preferred bidders, the Beacon Medical Group and Synchrony Healthcare, were backed by large, experienced international healthcare groups – University of Pittsburgh Medical Center and the Synchrony Healthcare Group, LLC respectively.

Table 3.2: Theory Framework in Both Cases

<table>
<thead>
<tr>
<th></th>
<th>National Treatment Purchase Fund (NTPF)</th>
<th>Hospital Co-location Project (HCP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embeddedness – structure of social relations</td>
<td>Yes/Perverse – Doctors and hospital managers</td>
<td>Yes/Blocking mechanism for would-be changers</td>
</tr>
<tr>
<td>Institutional Entrepreneurs</td>
<td>No/political ‘sticking plaster’ for on-going problem</td>
<td>Yes/Gallery of ‘for and against’ actors</td>
</tr>
<tr>
<td>Transaction Costs</td>
<td>Yes/Increased TCs</td>
<td>Yes/Increased TCs</td>
</tr>
<tr>
<td>Risk Transfer</td>
<td>Yes/Risk undertaken by private sector</td>
<td>No/Potential risk seen as ‘deal-breaker’</td>
</tr>
<tr>
<td>Perverse Incentives</td>
<td>Yes/Opportunities for great extra fees for hospitals and doctors taxpayer pays – overall welfare reduction</td>
<td>Yes/Incentive for existing actors in power to ensure that project fails even if welfare improvement could be demonstrated</td>
</tr>
<tr>
<td>Path Dependency</td>
<td>No/ NTPF was a new institution but its effect was most of its budget went into private hospitals</td>
<td>Yes/Trade Unions and many doctors and other health care staff were opposed any change from what had been in place</td>
</tr>
<tr>
<td>Power</td>
<td>Yes/Increased power of doctors and managers and civil servants controlling the revenue distribution</td>
<td>Yes/Potential for decreased power for incumbents as new force tries use political and economic force for change</td>
</tr>
<tr>
<td>Asset Specificity/Opportunism</td>
<td>Yes/Opportunities for hospital managers and surgeons to save budget and gain extra fees by manipulating the system</td>
<td>Yes/Assets of hospital buildings etc. would be immoveable and built on HSE property</td>
</tr>
</tbody>
</table>
3.5 Concluding Remarks

The HCP sought to change the institutional arrangement of the publically owned and managed hospital to a position where the hospital location would be inhabited by two distinct and separate entities. The land would be retained in public ownership but the private part would in some ways be ‘piggy-backing’ on, and deriving revenues and profits from, the advantage of proximity to the public part. This position would involve a shift in some power from those who currently have control of the situation to a new group who would be buying their way in. That is, loss of some power from public service executives and a gain in power to private sector business people. It is demonstrated on the framework by individuals, both directly and objectively influencing political organizations and subjectively as part of economic organizations to seek institutional change.

Pro-market politicians dominated the government of the time. They believed in rolling back the state and providing the private sector with opportunities to get involved with the provision of services once the preserve of the public sector. This group together with high net worth members of the medical profession and business backers saw an opportunity for gain. However, executives in the HSE together with medical professionals who support public medicine and trade unions representing public sector hospital workers all believed that HCP would see power and money slip away from their area of influence. Ultimately politicians and the promoters of HCP were thwarted in their attempt to alter the institutional arrangements by the more powerful senior civil servants in the Department of Health. However, it is open to question whether this project could have succeeded even without active opposition. The issue of the level of risk the private operators were taking, the position of the private health insurers, the poor understanding of how PPPs worked and the credit crunch brought about by the international financial crisis sealed its fate.

The medical profession seems split on the issue of whether the NTPF worked or not. Some who were quite critical of it nevertheless managed to use it and gained financially from it. Hospital management were able to gain by having a public patient taken off their list and reinstated as a private one under the NTPF. It created perverse incentives in some areas and undoubtedly channelled referrals to private
hospitals who might not have survived without this source of business. Increasing criticism of its operation from individuals directly through the media and collectively through political organizations put an end to its operation once one of these political organizations became a part of the government.
Chapter 4:

Ownership: The Case of Irish Nursing Homes, Public and Private

4.1 Introduction and Context

It is likely much of the adult population who survive into old age will spend the latter part of their lives in professional residential care. With the expansion of private, for-profit accommodation in Ireland in the last 15 years, along-side the voluntary sector and the state owned and run institutions, it is timely to ask whether the type of nursing home ownership affects efficiency and provision of quality care in the Irish nursing home industry.

In this chapter we pose a series of questions to examine whether public or private ownership, and by implication, motivation matters to the quality and efficiency of the service being delivered in the nursing home industry, using data on the entire Irish nursing home industry. In keeping with much of the literature on the topic, we ask: Does cost efficiency have an adverse effect on quality and how do we know? Does a higher weekly price for the maintenance of residents automatically lead to a higher quality service, and conversely does lower cost to the consumer imply lower quality? Does the ratio of staff to residents and the relative level of training of the staff affect the quality?

We address these questions using a new dataset compiled by the author from the Health Information and Quality Authority (HIQA), covering all 612 nursing homes registered since 2009 in Ireland, controlling for a range of socioeconomic and geographic factors. We focus on the ownership mix that prevails in the Irish nursing homes sector to examine the relationship between the cost to consumers and quality of service provided.

Our contribution is to test the following two hypotheses using a new dataset: whether costs are equal across public, voluntary, and private nursing homes, and whether
public and private nursing homes ‘react’ to identified deficiencies, which we use as a proxy for quality of care, at the same speed.

**Figure 4.1: Conceptual Map Chapter 4**

The great expansion of private for-profit nursing homes in Ireland and in Britain has raised questions over whether the profit motive is compatible with the provision of quality care for older people (Spector et al, 1998). Much of the literature suggests there is at least an adverse relationship between the two (O’Neill et al, 2003,
Harrington et al, 2011), though the debate is still contentious, with some authors, such as Buam (1999) suggesting regulation may be the solution to even out disparities, with still others suggesting private providers, working in chains of nursing homes, act as ‘white knights’ driving cost efficiencies, making it possible for the industry to continue to operate in the face of a poor economic outlook (Duhigg 2007). This chapter addresses some of the concerns raised in this literature.

The rest of this chapter is laid out as follows. Section 2 discusses previous contributions on the provision of public and privately owned nursing homes. Section 3 provides some international context and Section 4 discusses the data. Section 5 derives the models used to test our hypotheses, and section 6 concludes.

### 4.2 Literature on Public and Private Provision of Nursing Home Services

Older people, who may not be in possession of all of their faculties and who do not wish to upset their children or other close relatives, are unlikely to be the most vociferous of consumers. Nursing home care is, in many cases, chosen by family members and the ability of the resident to evaluate care quality or complain in the case of a perceived inadequacy of service is likely to be limited. This information asymmetry could provide an opportunity for profit maximizing institutions to make savings in areas which are hard to measure and assess. Comparison between the public and private sectors in nursing home care, for older people comes mostly from the United States and Canada.


Spector et al (1998) arrive at the similar conclusion that nonprofit homes provide greater quality than for-profit homes. They point to evidence that nonprofit nursing homes pay higher wages and charge higher rates to residents. Castle and Engberg
(2008) conclude quality of care in nursing homes is greatly dependent on staffing levels: not only quantity and ratio between staff to residents but the level of professional qualification and the consistency of care co-ordination and care practices. High staff turnover and the excessive use of agency staff can be unsettling to residents and can impact on quality. We will examine these issues using our dataset.

Hillmer et al (2005) conducted a review of 38 articles written in the United States and Canada between 1990 and 2002, where quantitative data was used to compare the quality of care between for-profit and not-for-profit nursing homes. Their conclusion was for-profit nursing homes provide lower quality of care in ‘many important areas of process and outcome’.

Harrington et al (2011) compared staffing levels and deficiencies in nursing home chains before and after purchase by private equity companies. They found that the homes controlled by private equity companies had lower nurse staffing hours and 36 per cent higher rates of deficiencies than government facilities.

From the literature, we ask: Does cost efficiency have an adverse effect on quality and how do we know? Does a higher weekly price for the maintenance of residents automatically lead to a higher quality service, and conversely does lower cost to the consumer imply lower quality? Does the ratio of staff to residents and the relative level of training of the staff affect the quality?

4.3 The international experience of differential nursing ownership

In the United Kingdom there has been a gradual drift from publically supplied residential care for older people to a predominance of privately provided care. Up to 1979 most residential care for older people in the UK was provided by the NHS, funded by national taxation. After this, funding was funneled through local authorities and the Department of Health and Social Security to private residential care, fueling a rapid expansion of this sector (Player and Pollock 2001).

New companies came into the UK market attracted by the demand of an ageing population and the guaranteed stream of revenue from the public sector. As an investment, nursing homes offered steady cash flows as 61 per cent their income was
paid for by local authorities. By the early 1990s there were twenty publically quoted, large-scale nursing home operators on the London Stock Exchange. Of these, only one survived to the turn of the millennium (Drakeford 2006).

Similar to most countries Switzerland has a variety of nursing home institutions with different origins and aims but they can be categorized as: ‘for-profit’, ‘not-for-profit’ and ‘public’. One third of these homes is public and managed by local authorities. Half are private non-profit institutions, which would be equivalent to our voluntary homes, and the remainder is private, for-profit concerns ranging from sole traders to partnerships to limited companies. Crevilli et al (2002) point to factors which make the operation of a free market in this industry unlikely.

First there is the natural local monopoly, particularly in geographically remote locations, which is also seen in the hospital sector. Swiss authorities consider the provision of nursing home care for older people to be a merit good –something that should be provided on the basis of need, rather than ability to pay – and so provide financial support out of general taxation.

The Swiss state regulates nursing home rates, which can act as a barrier to entry and limits the supply thereby creating a permanent excess of demand. The result of this is rationing by waiting list. The existence of financial support and regulation impacts on the potential differences between public and private and Crevilli et al (2002) conclude ownership does not make a significant difference in efficiency between the two sectors in Switzerland. In countries such as the United Kingdom, the United States, Canada and Switzerland there is a mix of ownership in the nursing home industry. There is a similar mix in Ireland, with a recent large increase in private involvement in nursing homes.

4.4 Background and Data Description

The data we compiled from HIQA show the provision of nursing home services in Ireland is characterized by a mix of ownership models. In our dataset, there are 404 private nursing homes, 65 voluntary, 131 public and some uncategorized or unknown. We describe these as: ‘for-profit’, ‘not-for-profit’ and ‘public’.
Of the currently trading nursing homes, one was established in 1545 under the reign of Henry VIII\textsuperscript{15}, three originate from the eighteenth century, thirty from the nineteenth century and a full one-third of all nursing homes commenced business since 2000.

The public nursing homes are owned by the state and administered by the Health Service Executive (HSE). These vary in age, the earliest was established in 1769 and the most recent in 2011. The average age of public sector nursing homes is 63 years. Many of the public institutions, which now house public nursing homes, started as workhouses, which were established under the Poor Law Act of 1838 and subsequently became community hospitals.

Over half of the 404 currently registered private nursing homes were established since 1997, the year that the Finance Bill effectively extended capital allowances, already available on industrial buildings and hotels, to nursing homes. We ascribe the increase in private nursing home provision to this policy change.

Investments in nursing homes became a legitimate way of reducing exposure to income tax for middle to high-income tax payers (Canniffe 1999). In addition AIB set aside IR£50 million to support the development of the Irish nursing home sector in response to the expected upsurge in demand for nursing home services (Creaton 1998).

In 2005 the financing of public sector nursing homes faced a greater problem with the publication of \textit{The Travers Report} into ‘the long-term practice of inpatient charges in health board institutions’, or to put it more plainly: the illegal charging of the elderly and the mentally and physically ill for shelter and maintenance. This illegal practice of charging people for these services had been in place for 28 years, and its termination provided even greater incentive for the private sector to become involved in the nursing home business.

To examine the relationship between ownership, cost and quality we have accessed all of the publicly available records of inspections at every registered nursing home.

\textsuperscript{15} The oldest known nursing home in Ireland is the Holy Ghost Residential Home in County Waterford, which dates from the sixteenth century and is a voluntary organization which is governed by a Board of Trustees.
in the county (up to June 2012) and compiled a database which counts: the name, county location and ownership status of all homes.

Our database also includes the average weekly charge for maintenance, the number of residents, their dependency level and the type and status of staff employed. For each nursing home we have taken each inspection (up to five), noted the date and counted the number of deficiencies which have been notified by the inspectors. A description of the variables used for the analysis is provided in Appendix A, and Table 4.1 below shows relevant descriptive statistics. Note some institutions have only one inspection on record and others have up to seven.

Table 4.1: Descriptive statistics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Obs</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>532</td>
<td>951.5</td>
<td>243.1</td>
<td>430.0</td>
<td>2518.0</td>
</tr>
<tr>
<td>Log of cost</td>
<td>532</td>
<td>6.8</td>
<td>0.2</td>
<td>6.1</td>
<td>7.8</td>
</tr>
<tr>
<td>Charge</td>
<td>532</td>
<td>1.0</td>
<td>0.3</td>
<td>0.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Action2</td>
<td>499</td>
<td>10.8</td>
<td>7.0</td>
<td>0.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Action3</td>
<td>265</td>
<td>12.8</td>
<td>8.1</td>
<td>0.0</td>
<td>52.0</td>
</tr>
<tr>
<td>Action4</td>
<td>93</td>
<td>15.2</td>
<td>9.3</td>
<td>1.0</td>
<td>51.0</td>
</tr>
<tr>
<td>Action5</td>
<td>26</td>
<td>13.2</td>
<td>10.5</td>
<td>1.0</td>
<td>45.0</td>
</tr>
<tr>
<td>Low dependency</td>
<td>534</td>
<td>17.6</td>
<td>12.3</td>
<td>0.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Medium dependency</td>
<td>519</td>
<td>2.5</td>
<td>3.7</td>
<td>0.0</td>
<td>28.0</td>
</tr>
<tr>
<td>Dependency²</td>
<td>519</td>
<td>19.9</td>
<td>78.8</td>
<td>0.0</td>
<td>784.0</td>
</tr>
<tr>
<td>Provinces</td>
<td>531</td>
<td>2.6</td>
<td>1.1</td>
<td>1.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Nurses</td>
<td>532</td>
<td>3.7</td>
<td>4.6</td>
<td>0.0</td>
<td>54.0</td>
</tr>
<tr>
<td>Carestaff</td>
<td>532</td>
<td>7.0</td>
<td>4.6</td>
<td>1.0</td>
<td>31.0</td>
</tr>
<tr>
<td>Resbycare</td>
<td>532</td>
<td>7.0</td>
<td>2.5</td>
<td>2.2</td>
<td>28.0</td>
</tr>
<tr>
<td>Resbynurse</td>
<td>520</td>
<td>17.2</td>
<td>8.6</td>
<td>3.1</td>
<td>48.0</td>
</tr>
</tbody>
</table>

We are using the deficiency count as proxy of quality and their improvement or dis-improvement over the inspections as a trend (coded as Action). Staffing level is also a mechanism by which quality is produced and so we look at these levels compared to the number of residents in a particular home and against their dependency requirement (coded below as resbycare and resbynurse respectively).
The location of nursing homes and their competitive environment within a county may also have a bearing on the quality delivered. To capture locational effects we type each nursing home by location as Dublin, Rest of Leinster, Munster and Connaught/Ulster in the variable *provinces*.

There are four levels of dependency noted in the HIQA reports: low, medium, high and max. The average weekly cost of care is €878 in private care, €1,669 in public care and €783 in voluntary nursing homes (HSE 2012). These averages are somewhat skewed by outliers.

Comparing these *dependency* levels with the weekly cost of care over the three ownership types it is clear that the private and voluntary homes are less expensive but residents who require the maximum level of care may be more likely to be found in the public homes. It may well be the case that those who are the most dependent are less demanding of staff than those who are more lucid and mobile.

When the dependency level is viewed with the staffing levels we note levels of staff per resident is lower in the private sector, but the distribution of the four levels of dependency does *not* vary greatly having a fairly even distribution over the three ownership types. If we look at the high level of dependency, for example, we note private homes have greater numbers of residents but with a lower ratio of staff per resident. This differential staffing by ownership may be the key to a profitable operation, and may explain the differences we see within the dataset. There is a greater amount of higher qualified staff, such as ‘Clinical Nurse Manager’ and ‘Staff Nurses’ in the public sector, whereas similar work is carried out in the private sector by care attendants.

Figure 4.1 illustrates the average weekly cost of residential care compared to staff numbers per resident by ownership type (upper panel) and over geographical area (lower panel). As previously noted there are lower levels of staff in the private sector. Putting the twenty-six counties on one scatter plot illustrated the predominance of Dublin where, as a general rule, the cost is higher but the number of staff per resident is spread across the spectrum.
Figure 4.1: Cost vs. Staff marked by Ownership Province
Our data show a clear difference between the public and privately owned nursing homes in relation to quality, cost, staffing levels, dependency, and location. We attempt to control for these effects using three models below.

### 4.5 Model Specification and Results

Our objective is to understand the effect of ownership on nursing home cost and quality. We first run an OLS regression using the natural log of weekly cost as the dependent variable against the regressors as in equation 1 below:

\[
\ln(cost) = \alpha_0 + \alpha_1 * Ownership + \alpha_2 * dependency + \alpha_3 * dependency^2 + \alpha_4 * Actions + \alpha_5 * \frac{Residents}{Nurses} + \alpha_6 * \frac{Residents}{Carestaff} + \alpha_7 * Provinces + \epsilon_i
\] (1)

Our results are set out in model (1) of Table 4.2 below, with heteroskedastic robust standard errors and p-values reported as standard.

As mentioned above, we control for the number and comorbid severity of nursing home residents seen by the various nursing homes in the regressors dependency and dependency\(^2\), while controlling for the numbers of care staff and nurses per resident in Resbynurse and Resbycare. Standard post estimation diagnostics were also carried out and detailed in Table 4.2.

Model (1) in Table 4.2 shows there is a clear difference in the cost of providing nursing home services in the private sector as distinct from the public sector. The cost difference, relative to the private sector, is roughly -4 per cent for voluntary nursing homes and +32 per cent in the public sector.

Though statistically significant, the coefficients on Resbycare and Resbynurse are relatively small (-0.12% and -1.1% respectively), so in answer to our first question, the levels of staffing do not appear to cause a large change in weekly cost.
Table 4.2: Regression analysis

<table>
<thead>
<tr>
<th>Description</th>
<th>lncost</th>
<th>x1</th>
<th>lncost</th>
</tr>
</thead>
<tbody>
<tr>
<td>main</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private ownership</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Voluntary ownership</td>
<td>-0.0381</td>
<td>0.584</td>
<td>-0.0579**</td>
</tr>
<tr>
<td></td>
<td>(-1.73)</td>
<td>-0.97</td>
<td>(-2.59)</td>
</tr>
<tr>
<td>Public ownership</td>
<td>0.321***</td>
<td>-0.793</td>
<td>0.299***</td>
</tr>
<tr>
<td></td>
<td>-12.72</td>
<td>(-1.68)</td>
<td>-10.66</td>
</tr>
<tr>
<td>Resident/care</td>
<td>-0.0117**</td>
<td>0.144</td>
<td>-0.0110**</td>
</tr>
<tr>
<td></td>
<td>(-2.74)</td>
<td>-1.52</td>
<td>(-2.65)</td>
</tr>
<tr>
<td>Resident/nurse</td>
<td>-0.000671</td>
<td>0.151***</td>
<td>-0.000488</td>
</tr>
<tr>
<td></td>
<td>(-0.70)</td>
<td>-5.42</td>
<td>(-0.52)</td>
</tr>
<tr>
<td>Connaght/Ulster</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dublin</td>
<td>0.332***</td>
<td>-1.827***</td>
<td>0.346***</td>
</tr>
<tr>
<td></td>
<td>-16.42</td>
<td>(-3.43)</td>
<td>-17.01</td>
</tr>
<tr>
<td>Munster</td>
<td>0.0541**</td>
<td>-1.481**</td>
<td>0.0665***</td>
</tr>
<tr>
<td></td>
<td>-3.19</td>
<td>(-2.99)</td>
<td>-3.89</td>
</tr>
<tr>
<td>Rest of Leinster</td>
<td>0.102***</td>
<td>-1.612**</td>
<td>0.111***</td>
</tr>
<tr>
<td></td>
<td>-6.31</td>
<td>(-3.26)</td>
<td>-6.75</td>
</tr>
<tr>
<td>Dependency</td>
<td>0.00804</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-1.59</td>
<td></td>
</tr>
<tr>
<td>Dependency^2</td>
<td>-9.65E-05</td>
<td>(-0.48)</td>
<td></td>
</tr>
</tbody>
</table>

| N                         | 519   | 519 | 507    |

*t statistics in parentheses
* * * p < 0.05, ** p < 0.01, *** p < 0.001

Location also matters. Private nursing homes operate in a competitive market within geographical limits where the strict mathematical average cost to a resident is under €900 per week. The cost variation tends to reflect the property market so unsurprisingly our regression analysis (Table 4.2) clearly demonstrates that Dublin is considerably more expensive than the other three provincial divisions. In comparison to Connaght/Ulster, Dublin is 33 per cent more expensive, the rest of Leinster is 10 per cent more expensive and Munster is 5.5 per cent more expensive.
In terms of severity and dependency, there is little difference between public and private nursing homes, with both dependency and dependency$^2$ showing small and statistically insignificant coefficients.

We find that, controlling for client severity, differential staffing, and location, a clear and very distinct cost premium exists for public sector nursing homes.

To check our results we ran a series of truncated regressions to verify the results of equation 1 according to:

$$\ln covest = \alpha_0 + \alpha_1 * Nurses + \alpha_2 * CareStaff + \alpha_3 * Actions + \alpha_5 * dependency + \epsilon_i$$

(2)

We found no substantial changes to our findings.

We ran a series of quantile regressions at the 10$^{th}$, 25$^{th}$, 50$^{th}$, 75$^{th}$, and 90$^{th}$ percentiles to test whether price dispersion existed at the tails, and though we find clear evidence of price dispersion at the tails, we can say it is not the case that a few, large nursing homes skew the results overly.

When the data were put together we observed there was an opportunity to create an unbalanced panel of nursing homes using the number of times visited by HIQA as a proxy for time.

The objective is to use this panel data to include variables at different levels of analysis. The panel consists of up to five inspections, or visits, by the HSE inspectors to each nursing home.

HIQA visits can be random, unannounced, pre-planned or as a follow-up to a previous visit. Each ‘visit’ is individual to a nursing home, and our dataset captures up to 5 visits per nursing home. Because they are not evenly spaced in time, i.e. annually or six monthly, the panel is unbalanced. There is no evidence to suggest private nursing homes were visited more or less frequently than public nursing homes. Thus the results below are not simply explained by the private sector having more inspections.
We are interested in analyzing the variables that vary over time under the headings of the different types of ownership.

The objective is to measure the level of responsiveness by ownership to correcting deficiencies, which have been reported by the inspection.

We estimate the following fixed effects regression for each sub-sample by ownership in an unbalanced panel format to examine how the number of visits by HIQA affected the number of actions over time.

\[
\text{Actions}_{it} = \alpha_0 + \alpha_1 \cdot \text{Visit}_1 + \alpha_2 \cdot \text{Visit}_2 + \alpha_3 \cdot \text{Visit}_3 + \text{Visit}_4 + \epsilon_{it} \tag{3}
\]

Model (3) in Table 3 estimates equation (3) for private nursing homes. Model (2) in Table 4.3 estimates equation 3 for voluntary nursing homes, and model (3) estimates equation 3 for public nursing homes.

**Table 4.3: Fixed Effects regression results across ownership**

<table>
<thead>
<tr>
<th></th>
<th>Private</th>
<th>Voluntary</th>
<th>Public</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actions</td>
<td>Actions</td>
<td>Actions</td>
</tr>
<tr>
<td>Most recent inspection</td>
<td>-2.359***</td>
<td>-2.810***</td>
<td>-0.849</td>
</tr>
<tr>
<td></td>
<td>(-4.12)</td>
<td>(-4.18)</td>
<td>(-0.39)</td>
</tr>
<tr>
<td>2\text{nd} most recent inspection</td>
<td>2.052***</td>
<td>1.823**</td>
<td>4.588*</td>
</tr>
<tr>
<td></td>
<td>(4.33)</td>
<td>(3.25)</td>
<td>(2.45)</td>
</tr>
<tr>
<td>3\text{rd} most recent inspection</td>
<td>3.853***</td>
<td>3.966***</td>
<td>2.849</td>
</tr>
<tr>
<td></td>
<td>(5.40)</td>
<td>(4.78)</td>
<td>(0.97)</td>
</tr>
<tr>
<td>4\text{th} most recent inspection</td>
<td>6.477***</td>
<td>6.065***</td>
<td>5.913</td>
</tr>
<tr>
<td></td>
<td>(6.30)</td>
<td>(5.11)</td>
<td>(1.40)</td>
</tr>
<tr>
<td>5\text{th} most recent inspection</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>_cons</td>
<td>9.999***</td>
<td>10.03***</td>
<td>8.912***</td>
</tr>
<tr>
<td></td>
<td>(15.11)</td>
<td>(12.88)</td>
<td>(3.62)</td>
</tr>
</tbody>
</table>

\text{n} statistics in parentheses
* \(p < 0.05\), ** \(p < 0.01\), *** \(p < 0.001\)
The results are relatively unambiguous: relative to the earliest recorded inspection, private nursing homes ‘react’ faster to rectify deficiencies noted by the HIQA inspectors than public nursing homes seem to be able to, reducing actions by -2.8 in the private sector relative to -1.24 in the public sector. The effect of an action on the public sector is also not statistically significant. The same pattern continues the further back we go.

The fixed effects regression results in Table 4.3 show the private sector number of ‘actions’ reduces at a considerably faster pace than the public sector.

Our second hypothesis was whether public and private nursing homes ‘reacted’ in the same way to identified deficiencies, which we use as a proxy for quality of care. Our results show they do not.

4.6 Conclusion

The goal of this chapter was to examine the issue of ownership in the nursing home industry using a new dataset. From the evidence we have looked at it is clear there is support for the view that ownership is an issue in the provision of nursing home care with respect to cost, efficiency and quality of care. From the evidence of these data, private sector operators prove themselves far more flexible in their ability to address deficiencies and care levels do not seem to be compromised.\footnote{As the age profile of the private sector establishments is much lower than that of the public sector it may well be that structural changes to newer buildings are easier to achieve. However, deficiencies cover a wide range of subjects, for example, some of them are concerned with training and record keeping as well as stricter measures of quality of care.}

The lesser ability of the public sector to address these issues is surprising. On the basis of these results we must reject both the hypothesis that public ownership is associated with lower deficiencies and the hypothesis that price is negatively related to the level of deficiency and staffing.

These hypotheses are derived from the suggestions in the literature that there is an adverse relationship between the profit motivation and quality of care. It is difficult to escape the suspicion that quality of care for the elderly has an adverse relationship with the profit seeking motivation.
It is simple to envisage that this might be the case in many areas of health care provision were it not for rigid and comprehensive monitoring, inspection and regulation. However, the nursing home sector is now well inspected and some high-profile cases of bad practice have ended in the closure of facilities in both the public and the private sectors. The increasing need for residential care is unlikely to be provided from the public sector due to economic constraints and the policy direction of the political environment.

This need will be provided by the private sector, but if we are to avoid some of the pitfalls encountered in other countries, we will have to balance the incentive to grow these businesses with the need to ensure that quality and profitability are not adversely related.

4.6.1 Fair Deal

The current ‘Fair Deal’ scheme being operated by the HSE brings in residents who have varying levels of income and assets and these individuals are cared for in public, voluntary and private nursing homes. The scheme, which came into effect at the end of 2009, allows the resident to pay what they can afford taking income and assets into consideration and the Government pays the balance. In the case where individuals who are in need of residential care and who may not have much income but may possess assets, such as a house, a charge is placed over the asset and repayment of the cost of care is taken after the person dies. The National Treatment Purchase Fund (NTPF) was charged with the task of negotiating fixed maximum prices with private and voluntary nursing homes. By the end of 2010 ninety-nine per cent of private and voluntary nursing homes had agreed prices with the NTPF (NTPF 2010). Private and voluntary homes which are involved in the scheme have agreed a certain price with the HSE but must conform to criteria and standards set down by the HSE. This may have the effect of limiting the price in the market but maintaining a certain minimum level of quality. However with the weekly cost in the private sector being considerably lower than the cost in the public sector and the fact that agreement was reached with such a high proportion of the homes in a relatively short time period we can conclude that negotiations were not difficult and the operation of the market will not be adversely affected. If the private sector continues to display
the level of agility evidenced in this study together with a high level of monitoring from the authorities this can only be good news for the future requirements of older people in Ireland. But as the sector expands and individual proprietors age and retire, succession planning and who or what entities will be in control of private nursing homes in the future may have an input into government policy. As we have seen in examples of the UK, the US and Canada various issues over time have caused the consolidation of the sector into large multiple-branch operations where the level of profitability appears to be adversely related to quality. In this case the maintenance of high standards may cause market failure and force the public sector to re-engage in the business at a higher than ever cost to society.

4.6.2 Limitations
At the time of compiling the database (May 2012) every nursing home which had been registered in the state was examined and the details from up to five HIQA inspections per home were included. Using a deficiency count as a measure of quality has been well established by other researchers (O'Neill et al. 2003, Harrington et al. 2001, Harrington et al. 2011, Nyman 1988). Simple counting of deficiencies does not however apply a weighted value to the deficiencies. Not all deficiencies could be characterized as having the same level of seriousness or the potential for the same level of adverse consequences. For example, many deficiencies involve inadequacy of procedure, training or record keeping while others refer to the need for structural alteration of a building. The cost of maintaining records of medication given to patients may be negligible but vitally important in avoiding a serious mistake whereas the cost of building work may be high and make little difference to resident’s wellbeing in order to comply with regulations. However it is the ability to address shortcomings in between inspections, whether costly or requiring re-training, which is the measure of the value in using deficiencies as a proxy for quality.

With the inevitable increase in the size of the private sector and the retreat of the public sector in the face of continuing austerity, government needs to ensure that the ridged monitoring of this sector for quality outcomes is maintained and strengthened.
Chapter 5:

Does ownership affect the provision of health services in Ireland? - The Case of Hip Replacements in Public and Private Clinics

5.1 Introduction

In this chapter we examine the differences between public and private medical clinics using hip replacements as the vehicle to ascertain the ownership effects on the provision of professional services. Therefore the unit of analysis being examined is that of ownership. Ireland has always had a mixed delivery system but the recent increase in private facilities has made the question more relevant. This study seeks to partially replicate a paper by Andersen and Jakobsen (2010) which posed this question in terms of the Danish health system. Their study called for more research in varying institutional contexts to test their conclusions. The Irish health service is such a variation and it is hoped that analysis of the available data for hip replacements in Ireland may enhance the knowledge of the potential differences that ownership may have on the provision of services.

The Irish health system differs from the Danish system in that the mix between public and private is more complex and therefore whilst relying on the methodology provided by Andersen and Jakobsen, modifications have been made to establish similar information in the Irish context.

5.2 Background

5.2.1 Chapter Layout

This chapter is organized as follows: section 2 examines at the background to the study and will outline some of the differences in environment between the situation in Denmark, where the original study took place, and those that pertain in Ireland. Section 3 gives a detailed description of the Irish health system in its public and private aspects and the impact on incentives produced by private insurance. The
fourth section outlines the system with particular reference to hip surgery and remuneration of the surgical practitioners. This is followed by a description of the methodology and the data. In this section we will outline the deviation from the Danish study necessitated by the unavailability of data in the Irish context. Much of the data, being primarily qualitative has been distributed throughout the chapter. Then there is the analysis of the findings followed by concluding remarks.

5.2.2 Data Collection
As with the Danish study (Andersen and Jakobsen 2010), it is not possible to examine in detail the issues of cost, efficiency and profitability. Much of this information is inaccessible due to what are claimed to be ‘commercial sensitivity’. In Denmark much of the quantitative data is openly available from the Danish Hip Arthroplasty Register and other national databases. In Ireland data relating to public hospitals is available from the ESRI however up to now there has been no information on the private hospitals to make the type of comparisons necessary. To fill this gap the author has carried out a survey of private hospitals to gain data in relation to hip replacements and quality.

Most of the information for this study comes from 12 interviews carried out with professionals involved in hip replacements. Nine were conducted with orthopaedic surgeons, two with the CEOs of private hospitals and one with the CEO of a public hospital. In Denmark 20 interviews were done. Obviously we have less interviews than the Danish case study. However, Ireland with a population of 4.5 million has the smallest number of orthopaedic surgeons, in relation to its population, in Western Europe (IITOS 2009).

The Irish Institute of Trauma and Orthopaedic Surgery (IITOS) currently lists 108 members on its website, of who 21 are honorary members including retired surgeons. Our inquiries with the profession lead us to believe that there are a total of 120 orthopaedic surgeons operating in the Republic of Ireland of which we identified 40 who are specialists in hip and knee replacement (see Table 5.1). Denmark has a population of 5.5 million and has in the region of 450 orthopaedic surgeons (Pedersen 2006, World Bank 2010). We therefore feel our sample is of adequate size given the differences in population and the number of applicable specialists.
In section 4 we describe the Irish health system in greater detail and it will be clear how the line between the private and public sectors are more blurred than they appear in Denmark.

**Figure 5.1: Conceptual Map Chapter 5**
Table 5.1: Current numbers of permanent consultant posts and consultant/population ratio by HSE hospital group

<table>
<thead>
<tr>
<th>Hospital group:</th>
<th>Population*</th>
<th>No. of Consultant Posts</th>
<th>Pop per Consultant.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dublin North:</td>
<td>534,521</td>
<td>16</td>
<td>1/33,407</td>
</tr>
<tr>
<td>Dublin South:</td>
<td>870,777</td>
<td>13</td>
<td>1/66,982</td>
</tr>
<tr>
<td>Mid-West:</td>
<td>361,028</td>
<td>5</td>
<td>1/72,205</td>
</tr>
<tr>
<td>North East:</td>
<td>394,028</td>
<td>5</td>
<td>1/78,805</td>
</tr>
<tr>
<td>South East:</td>
<td>460,838</td>
<td>6</td>
<td>1/76,806</td>
</tr>
<tr>
<td>Southern:</td>
<td>621,130</td>
<td>7</td>
<td>1/88,732</td>
</tr>
<tr>
<td>West/NW:</td>
<td>651,385</td>
<td>18</td>
<td>1/36,188</td>
</tr>
<tr>
<td>Total</td>
<td>4,230,778</td>
<td>78</td>
<td>1/54,240</td>
</tr>
</tbody>
</table>

Source: (IITOS 2009) *Population at the time of the 2006 census

5.2.3 The Danish System

The welfare state tradition is well established in the Nordic countries and Denmark in particular has a well-organized universal health system with which the population express continued satisfaction. Equal access to free health care and community solidarity are important underlying principles (Strandberg-Larsen et al. 2007). The Danish system is not without its faults. Danes have a shorter life expectancy than most other Europeans including the Irish. This position in relation to Ireland was the reverse twenty-five years ago (World Bank 2011b). Also, cancer survival statistics are much worse in Denmark when compared to their Nordic neighbours (Berrino et al. 2009). There are part-payments for some medical services and this has prompted the development of a private health insurance market. There is also in Denmark a growing private sector but only 2 per cent of the overall number of hospital beds is private. Even at this the private sector may be considered a threat to the principle of equity in, or a practical supplement to, the existing system. Thus there is a clear demarcation between the private sector and the public sector. Some orthopaedic surgeons work in both sectors. Some work exclusively in one sector. This makes seeking to study the behaviour and attitudes of surgeons one of the most practical ways of observing potential differences between public and private provision. In Ireland the private sector pervades the public facilities through the traditional practice of medical and surgical professionals and herein lays one of the principal differences in the systems in the two countries. The Irish system is discussed in detail in section 5.4.
5.2.4 Incentive Differences Between Public and Private

We compare the public and the private sectors by assessing professional behaviour, treatment quality and patient satisfaction in the case of hip replacements we attempt to answer these questions:

- Do the two sectors behave differently in the way they select their clients?
- Are the patients subjected to different standards of treatment depending on which service they choose or are compelled to use?
- Are the clinical results better in one sector that the other?
- Are users of the service more satisfied in one sector over another?

Andersen and Jakobsen (2010) point to the fact that while comparisons have been made between public and private service provision there is little evidence for services where the decisions are made by professionals who possess highly specialized knowledge. This is where professional providers of services differ from other sources of service. Their decisions are based on judgement, which in turn are reliant on specialist education and experience. This makes it difficult to measure performance by those outside of the profession and therefore there is a reliance on professional bodies to self-regulate and the existence of professional standards or norms (Andersen and Blegvad 2006).

Macdonald (1995, p.1) writing about the sociology of professions defines professions as ‘occupations based on advanced, or complex, or esoteric, or arcane knowledge’. The functionalist sociology of professions suggests that clinical procedure will be regulated by professional norms and therefore we can expect no difference in these procedures in whichever sector they are being delivered.

We will test this hypothesis using our newly gathered data.

On the face of it private clinics have a stronger incentive to select patients and provide treatments on the basis of financial gain but as we shall see incentives in this area are more complex than they may seem at first. Private hospitals in Ireland appear to have a better satisfaction rating than their public counterparts but in most cases their patients have been able to make a choice and these choices may have been made on the basis of non-clinical factors such as perceived comfort, shorter
waiting times and exclusivity (Boilson et al. 2007, NTPF 2011, Watson and Williams 2001). It may have its cultural origins in the public schemes like the workhouses of the 19th century but some Irish people have an inclination to believe that private services are better than public services and the ability to access them demonstrates social status. This can be demonstrated in another area of the health service. The uptake of private nursing home places since the introduction of the Nursing Homes Support Scheme has increased substantially. Publically run nursing homes which for many years had long waiting lists for admittance due to high standards are now very accessible (Author’s interview with NTPF).

Patients choosing private hospitals are likely to have a higher income reflected in their higher level of education. They will also have had a choice and having made the choice personally they will display a need to see it as the better option, to rationalize and maintain cognitive consistency. Watson and Williams (2001) found that the strongest criticism of the public health sector came from people who were in the Professional and Managerial social group and those with private health insurance who would be less likely to have experience of the public sector.

Publically provided services and public hospitals in particular are often seen by the community as institutions in which they have a stake and through the democratic process are entitled to have a say in how they are run and organized. Public representatives, who require the support of the population for their survival in that role, have an incentive to interfere in the running of institutions if they have the power to do so. These constraints do not affect private hospitals to the same extent except that they are required to stay within proper statutory regulations. Public institutions may not have a clear mission or a precise chain of command. The private sector’s mission is to enhance shareholder wealth through profits and this is best achieved with good management structures. Private clinics have the autonomy to pursue increased income and reduced costs by scheduling as many procedures as is possible within their physical limitations. In this way they can offer a timely appropriate service to hip and knee patients which could not be done in the public system where pre-booked operations can be cancelled due to some other happening in the public hospital. A private clinic is reimbursed for each procedure episode which is completed whereas the public hospital is working within a block grant which is based on what was required in previous years and is not contingent on the
completion of specific numbers of procedures. In other words, private clinics’ income is dependent on activity and public hospital income is not.

Following the lead of the Danish study (Andersen and Jakobsen 2010) it is useful to list the reasons why public and private clinics are similar enough to make meaningful comparisons of incentives, behaviour and performance. In using the one treatment category of hip replacements we control for the large difference in the intake of patients and their diagnosis. Second, many surgeons work in both the public and the private sector. Some surgeons work exclusively in the private sector. There is no evidence of surgeons working exclusively in the public sector. There is a high level of professional training, professional body supervision and individual autonomy over their patients in both sectors.

This chapter examines ownership differences in the provision of hip replacements. The chapter contrasts behaviour and performance under public and private ownership. For example, are surgeons incentivized by their payment system to treat patients differently in one sector as opposed to another? Is their behaviour and that of hospital managers influenced by economic considerations and are the outcomes different? It is important to note that a number of specific factors have shaped the structure of the Irish hospital sector. The following section describes these factors.

5.3 Institutional Context: Aspects of the Irish Health System, Public, Private and Insurance

5.3.1 Introduction
There are a number of institutional factors which apply to the Irish health system. We now describe these and then proceed to analyse the contrasts between the public and private sectors. Responsibility for the health system in Ireland is exercised through the Government Department of Health (DoH) which until recently was known as the Department of Health and Children (DoHC). The Department of Children is now a separate entity since the change of government in March 2011 but both terms are used in connection with the recent past. The Health Service Executive (HSE) is responsible for the provision of health care and personal social services. This single body replaced regional health boards which had been in place since
responsibility for health was transferred from the county councils in the early 1970s. The Irish health system is almost 80 per cent funded through taxation (McDaid et al. 2009).

Historically most Irish hospitals were voluntary hospitals – that is hospitals which were run by charitable or religious organizations. In the twentieth century new hospitals were opened and run directly by the local authorities at first and then by the DoH and recently by the HSE. The distinction between voluntary hospitals and purely public hospitals is now largely symbolic as all public hospitals come under the control of the HSE although the voluntary hospitals still maintain their own boards of governors. For simplicity, voluntary and public hospitals will be referred to as public hospitals. Recently there has been the growth of a viable, private, for-profit hospital sector.

5.3.2 Health Insurance in Ireland
While direct political interference is not possible with the private sector much of their revenue comes from insurance companies, particularly the Voluntary Health Insurance Board (VHI) trading as ‘VHI Healthcare’. VHI Healthcare generally referred to as ‘the VHI’ was set up in 1957 to provide private health insurance to those who could afford private health care but were not eligible as public patients. It is a statutory corporation whose sole shareholder is the Minister for Health. Since the 1990s health insurance has been open to competition and there are two other big players in the field – Laya Healthcare17 (originally Bupa) and Vivas Health (Turner and Shinnick 2008). The VHI provides in excess of 70 per cent of the revenue for a private hospital (Author interview, CEO 1(Nolan and Nolan 2004)). The VHI is the largest health insurer in the field and if the VHI decides that it will not provide cover for its subscribers at a new private hospital then that hospital’s viability is put into question (Interview with author). The Cork Medical Centre, which was set up with a €90 million investment was closed and a liquidator was appointed due to the fact that the VHI would not approve cover (Roche 2011). Up to July 2011 a second source of revenue for the private sector was referrals from the National Treatment Purchase Fund (NTPF) which was another body under the control of the Department of

17 In 2012 Quinn Healthcare who took over the Bupa brand changed its name to Laya Healthcare following a management led buy-out
Health. Public patients who had waited in excess of three months were entitled to be treated by the NTPF who purchased treatment in either private or public hospitals on their behalf. Where competition existed – for private patients or public patients treated privately under the NTPF – the payment from the major insurance companies and the NTPF was identical. Competition is only among those patients whose treatment commands a fee either paid for personally or a third party.

Many commentators opposed to the NTPF accused it merely being an agency to nurture and support the fledgling private hospital sector. All of the surgeons interviewed expressed either a neutral or somewhat disapproving attitude to the NTPF. The following is a typical comment:

‘I think that the NTPF is a very false economy. I think that if they took the money that they put into the NTPF and just resourced the hospitals appropriately then that work could all be done locally but they don’t do that and that’s a huge false economy’ (Surgeon S7).

The VHI’s schedule of fees is negotiated with the professional bodies and with both public and private hospitals. These fees are usually mirrored by the other two main health insurance companies, Vivas and Quinn (now known as Laya):

‘….VHI is very much the dominant player in the market so if VHI cuts its rates as night follows day Quinn drops to exactly the same rate and Vivas drops to exactly the same rate and then the NTPF drops to exactly the same rate as well and so there’s no competition there…’ (Surgeon S6).

The NTPF had a distorting incentive on the public hospitals. If they had a patient who had a complex but not life threatening condition it was possible to save part of their budget by delaying treatment until the patient was eligible for the NTPF. At that point the patient may have been taken to a private hospital to be treated or the hospital may have gained on the double by having the same patient treated in their own hospital but now with the addition of fees paid by the NTPF:

‘……hospitals are now selecting out the complex cases and saying: ‘now leave them on the waiting list and eventually the NTPF will scoop them up and that’s why you get what’s in your list about co-morbidities, the levels of co-morbidities are far higher in the NTPF patients’ (Surgeon S6).
The possibility of this happening was stated by one surgeon and instinctively it is believable but as it was not referred to by others interviewed it is not possible to say if it is a widespread practice or simply one of the potential perverse incentives brought about by the activities of the NTPF.

5.3.3 The Co-existence of Public and Private Provision of Hip Replacements

In examining the differences between public and private hospitals in Ireland it is necessary to understand that it is not an open, competitive market in the way in which that term would normally be used. There are a limited number of private hospitals where hip replacements are carried out. At the time of this study (Spring 2011) there were nine private hospitals carrying out this procedure with several others stating that they would be starting hip replacements within the next year. In the public sector there are eighteen hospitals which specialize in joint replacement with some of this work carried out in other public hospitals (see Table 5.2). Within these two types of hospitals patients can be either public or private. In the public hospitals all citizens are entitled to free accommodation and treatment but many people opt for private treatment and approximately 50 per cent of the population held private medical insurance in the recent past (Turner and Shinnick 2012, Finn and Harmon 2006) although this figure has declined somewhat in the last couple of years. This suggests that some of the community has a lack of confidence in the public system. Patients who are admitted to a public hospital via private consultation will be treated as private patients and must pay for treatment out of their own resources or through medical insurance. In the private hospitals most of the patients are in the latter category. However but due to the work of the NTPF public patients who have been on a waiting list for longer than three months were able to have their treatment purchased for them in a private hospital (see Figure 5.2).

When comparing public and private hospitals in the provision of hip replacements we take all hospitals which are under the control of the HSE, whether considered voluntary or not, to be public hospitals. Equally we take non-government controlled hospitals to be for-profit private enterprises. Some private hospitals have a tradition going back to the status of a voluntary institution and may stress this aspect in their literature but are nevertheless private and must operate to make a profit.
Part of the rationale for the formation of the HSE in 2005 was to remove the influence which local politicians had on the old health boards. Political interference was seen as an impediment to the long-term interests of and improvement of the health service. Rationalization and re-organization of the service had been thwarted many times by politicians protecting local interests (O’Morain 2007). Efficient hospitals in that system ended up supporting less efficient ones which have little incentive to improve matters. Taking all hospitals under the control of the HSE did not improve that aspect of control but the abolition of the health boards made reform on a national scale more possible.

**Table 5.1: Hospitals currently carrying out hip replacements in Ireland***

<table>
<thead>
<tr>
<th>HSE Area</th>
<th>Public Hospitals</th>
<th>No.</th>
<th>Private Hospitals</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dublin North/North East HSE Area</td>
<td>Beaumont, Cappagh Connolly Mater</td>
<td>4</td>
<td>Mater Private Sports Injury Clinic</td>
<td>2</td>
</tr>
<tr>
<td>Midlands/Dublin East Coast/Dublin South West HSE Area</td>
<td>Kilcrene, Tullamore Navan St. Vincent’s Tallaght St. James’s</td>
<td>6</td>
<td>Beacon Blackrock Clinic Hermitage Auteven</td>
<td>4</td>
</tr>
<tr>
<td>South East/Southern HSE Area</td>
<td>Cork UH, Kerry General Waterford</td>
<td>3</td>
<td>Shanakiel Whitfield</td>
<td>2</td>
</tr>
<tr>
<td>North West/West/Mid-West HSE Area</td>
<td>Letterkenny Mayo General Merlin Park MWR Croom Sligo General</td>
<td>5</td>
<td>Galway Clinic</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>18</td>
<td></td>
<td>9</td>
</tr>
</tbody>
</table>

*Sources: (IITOS 2009); (National Patient Treatment Register 2010) *Other public hospitals provide some limited elective orthopaedic service.

Large regional public hospitals in Ireland cater for most of the principal medical disciplines and some are also teaching hospitals. There are many different competing interests and competition for beds. At times when there are a lot of emergency
admissions elective surgery needs to be postponed. Many of the private hospitals started by doing only elective work and therefore the planning and organization of the work was likely to be more efficient. This together with well-structured management and a clear mission goal made private clinics attractive to surgeons and patients alike.

**Figure 5.2: Patient’s Progress Flow Chart**

![Patient’s Progress Flow Chart](image)

Patients who have insurance cover or who are in a position to pay for their hospital treatment ‘out-of-pocket’ may opt to ‘go private’. People in this position, on the advice of their doctor, may choose treatment at a private facility. If patients are satisfied that the level of treatment will be equal in the private facility then it may be the non-clinical aspects of the hospital which they might find attractive. Some private facilities have the décor resembling a luxury hotel and they may prefer the sense of exclusivity. Public hospitals operate within the financial allocation granted to them on an annual basis from the HSE. There are plans to alter the system whereby hospitals will be paid on the basis of their actual activity – ‘the money follows the patient’. As it currently stands elective treatments such as hip replacements must compete with all the other disciplines, including Accident and Emergency, for its share of the overall budget. Public hospitals also get revenue from
treatments to private patients. In addition to this they used to get revenue from treating public patients who were sent to them via the NTPF. However the NTPF was restricted to refer no more than 10 per cent of their patients to public hospitals. Despite their budgetary position, public hospitals have a continued incentive to keep their private business. Private patients are a lucrative source of revenue for the hospitals and it is an area where they can compete with private facilities due to the universal entitlement of citizens to a bed in a public hospital. The VHI and the other insurers do not pay public hospitals the full economic cost of the accommodation, food and treatment (Finn and Harmon 2006, Turner and Shinnick 2012) arguing that this portion of the cost of hospitalization is a free entitlement. The private hospitals do not have this advantage.

Private clinics have traditionally earned their revenue from elective work such as joint replacement and cataract extractions. These routine operations can be planned and are certain to be carried out and therefore may be budgeted to expectation. Some private hospitals now have accident and emergency departments but there is an upfront charge for using them and the limited opening times means that they are unlikely to receive the worst aspects of emergency departments in public hospitals. The revenues of private hospitals come from patients’ personal funds, insurance companies or from the NTPF. Private clinics employ orthopaedic surgeons many of whom also work in public hospitals. Some work in more than one public hospital and more than one private hospital. This is attractive to the surgeons as they have a range of potential locations in which to treat their private patients.

Difference in the independence of the two sectors to carry out their objective functions may not be as great as would be expected. The private sector is very much dependent on Government policy and the support of the VHI. So while direct political interference is not an option for politicians they can still exert some influence. Private companies have the ability to resort to the courts in the event of their interests being unduly compromised. The public sector did have a perceived level of interference when they were controlled by the Health Boards as the boards were managed by practicing politicians. Since the creation of the HSE this problem has been ameliorated but has given rise to the accusation not being accountable (Long 2007). So both sectors have a more equal ability to pursue their goals but within the control of government policy. As Stiglitz (1991) points out the principal
The dividing line between public and private institutions is that private concerns have hard budget constraints and therefore face the possibility of bankruptcy if they do not perform. In public concerns the budget constraint may be softer. In the past it was assumed that government had the ability to compel citizens to pay whatever taxes it deemed fit and therefore allow public institutions to continue in existence long after a private company would have gone out of business as if there is a perceived societal need for it. In the current economy this assumption can no longer be sustained. In this chapter we are examining the perceived differences between the public and the private sectors with specific reference to hip replacements. The criterion for comparison is incentives, behaviour and outcomes.

5.4 Hip Surgery in Ireland

In the following sections we will describe the context in which orthopaedic surgeons function in the Irish health system. We describe the hip replacement operation, economic issues which may impact on the procedure and also training, remuneration and incentives for the surgeons and other actors in the institutions where they work. Examining the issue of public verses private provision of services is complicated by the fact that most surgeons work in both sectors. This is an additional institutional factor and together with the collection of data and a review of relevant literature provides a basis to answer the questions which we described in earlier sections.

Wear and injury to hip joints is usually something which occurs over a lifetime. Although attempts at hip arthroplasty were developed over three centuries the replacement of the hip joint with prosthesis in modern times was pioneered by Professor Sir John Charnley, in the United Kingdom in the 1960s (Gomez and Morcuende 2005). The procedure has changed little over 40 years but the improvement in the science of the implants, the equipment and the skills of the surgeons it is an operation with a predominantly successful outcome. Hass and Sculco (2005) claim that the success rate of hip replacements in the United States 10 years after surgery is 90 – 95 per cent and after 20 years it is 80 – 85 per cent. Patients requiring hip replacements may have discomfort or pain and their condition may have a considerable impact on the quality of their lives but often they are not
otherwise unwell. Most hip replacement patients are over 55 years although the procedure is also carried out on younger patients.

Hip replacement can be required as an emergency operation but the majority of cases are elective and therefore can be planned in a methodical fashion. The outcome usually results in a considerable improvement on the quality of life for the patient and can restore a level of mobility which may have been absent for many years. Because of these factors hip surgery can be carried out in facilities which are less complex than might be required for cardiology or oncology patients and so is a good case on which to make comparisons between the public and private hospitals and test the question as to whether ownership is a factor in the perceived differences (Andersen and Jakobsen 2010).

In Ireland hip replacements are carried out in eighteen public hospitals (Table 5.2) some of which are large general hospitals. Others such as Cappagh National Orthopaedic Hospital in Finglas, Dublin and the Mid-Western Regional Orthopaedic Hospital, Croom, Co. Limerick are specialist orthopaedic hospitals. Out of twenty-five hospitals examined in the private sector, nine clinics were identified as carrying out hip replacements at the time of this study (Spring 2011). A number stated that they did not carry out any orthopaedic work. Others did orthopaedic work but did not do hip replacements but were intent on commencing the operation in the near future. Some were unable to co-operate with the study.

5.4.1 Autonomy of Surgeons
Professional managers will always look for ways to cut spending and most surgeons agree that it is common sense to take economic issues into consideration provided that it doesn’t compromise the best outcome for the patient. There does not appear to be any wish on the part of hospital managers or CEOs to interfere with their autonomy in clinical matters. Private clinics tend to get a greater amount of uncomplicated work when compared to their public counterparts. But in most cases this is as a result of the choice made by the surgeon and very often that is based on the availability of back-up emergency services, equipment and personnel.

Surgeons maintain that the choice of implant is strictly theirs but admit that everybody involved is aware of the greater financial constraints on the service in the last couple of years and that it makes sense to consider rationalizing the variety of
available implants and group together various institutions to ‘bulk buy’ and drive down the price. There is beginning to be an effort on the part of management to bring to the attention of the surgeon the economic implication of choices which have been made:

‘Of course the management would always like if it was cheaper, or that, but you have one chance of putting in an implant and you have to do it correctly so your technique is important but the implant is just as important’ (Surgeon S1).

This appears to be as prevalent in the public hospitals as in the private ones. Managers may feel that some surgeons are using excessively expensive implants because that was how they were trained and that they need to be reminded of the reality of budget constraints:

‘There is an increasing amount of pressure shall we say, based on the recession and the economics of the situation, from the HSE, from hospital management etc., to choose less expensive implants and we are becoming more aware of the corporate responsibility but we want to do the best for an individual patient and if that involves using a very expensive implant I don’t want somebody telling me that I can’t use a €13,000 implant if it’s ideal for that particular patient’ (Surgeon S8).

5.4.2 Waiting Times

The one clear difference between public and private clinics is that waiting times for public patients are longer. Public patients can skip the queue and get faster service if they can raise the money and opt to ‘go private’. Waiting lists in themselves are not a perfect metric for measuring performance (see Chapter 3). Waiting times vary considerably over different geographical areas (see Table 5.3) but it is possible for surgeons to organize matters with the local GPs to keep the waiting lists down. The amount of waiting time which has to be tolerated by those in the public system is not something that the consultants can do anything about. As it is, Irish orthopaedic consultant surgeons do up to twice as many hip replacements each year as their continental European or UK colleagues despite the fact that less than half the number of hip replacements are done in Ireland (IITOS 2009). This is a function of the small population of surgeons in relation to the general population. Ironically, some areas which have the least resources, in terms of surgeons and facilities to work in, are some of the more efficient when dealing with waiting lists. These are the regions
where productivity is highest and where the surgeons perform the most number of procedures. This situation, if not carried to extreme, may result in an increase in the level of skills and thereby the efficiency of the surgeons in this region.

Table 5.2: Waiting Time for Hip Replacement

<table>
<thead>
<tr>
<th>Public Hospital</th>
<th>No. of Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Median</td>
<td>4</td>
</tr>
<tr>
<td>Beaumont</td>
<td>5</td>
</tr>
<tr>
<td>Cappagh</td>
<td>3</td>
</tr>
<tr>
<td>Connolly</td>
<td>0</td>
</tr>
<tr>
<td>CUH</td>
<td>2</td>
</tr>
<tr>
<td>Kerry General</td>
<td>1</td>
</tr>
<tr>
<td>Letterkenny General</td>
<td>3</td>
</tr>
<tr>
<td>Kilcrene</td>
<td>2</td>
</tr>
<tr>
<td>Mater</td>
<td>8</td>
</tr>
<tr>
<td>Mayo General</td>
<td>4</td>
</tr>
<tr>
<td>Merlin Park</td>
<td>3</td>
</tr>
<tr>
<td>Tullamore</td>
<td>7</td>
</tr>
<tr>
<td>MWR Croom</td>
<td>1</td>
</tr>
<tr>
<td>Navan</td>
<td>4</td>
</tr>
<tr>
<td>Sligo General</td>
<td>3</td>
</tr>
<tr>
<td>St. Vincent’s</td>
<td>5</td>
</tr>
<tr>
<td>Tallaght</td>
<td>6</td>
</tr>
<tr>
<td>Waterford</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: (Culliton 2010)

5.4.3 Surgeons’ Training

The Irish Medical Council ensures that Irish surgeons are trained to the highest standards and that training is kept up to date. Orthopaedic surgeons in Ireland operate under the direction of the Medical Council. All surgeons in the past have maintained a very high level of continuous learning with numerous meetings, conferences (national and international) and constant review and sharing of journals. This is particularly prevalent in the large teaching hospitals where constant conferencing is enhanced to include the trainee surgeons. However this practice has now been made compulsory by the Medical Practitioners Act 2007 in which working doctors, in all disciplines from 1st May 2011 are legally obliged to participate in a Professional Competence Scheme. Therefore there is a consistency of competence in the professional norms practiced by orthopaedic surgeons. Differences of procedure
or choice of equipment or implants can be attributed to the location and culture of where the surgeons did their postgraduate training. Those that trained in the US and Canada may have differences from those who trained in the UK and continental Europe. As most of the consultant surgeons operate in both the public and private sectors the prospect of any discrepancy between clinical practice in the public and the private sectors is unlikely.

5.4.4 Surgeons’ remuneration and incentive

“We trust our health to the physician: our fortune and sometimes our life and reputation to the lawyer and attorney. Such confidence could not safely be reposed in people of a very mean or low condition. Their reward must be such, therefore, as may give them that rank in the society which so important a trust requires. The long time and the great expense which must be laid out in their education, when combined with this circumstance, necessarily enhance still further the price of their labour” (Book 1, Chapter 10) (Smith [1776] 1952).

Consultant orthopaedic surgeons who work in public hospitals have a contract where they are paid a fixed salary for their public work but may also treat a percentage of private patients in the public hospital. For their private work they get paid a fee mostly through insurance companies like the VHI. In addition many surgeons also do other work in private hospitals. Some surgeons work only in the private sector. There is no evidence of orthopaedic surgeons working exclusively in the public sector. At any given time a consultant who works in both sectors may have a mixture of public and private patients in a variety of different hospitals whose treatment is being paid for in a number of different ways.

Surgeons are paid ‘fee per item’ for private work whether in a public hospital or in a private one. The amount of this fee is largely determined by the insurance companies and the VHI’s schedule of fees in particular. In other systems this would be a more credible reimbursement scheme but the Irish situation is complicated somewhat by the Medical Consultants’ Contract which allows the consultant to perform work on private patients in public hospitals in proportion to the number of beds which are set aside for private patients – usually 20 per cent (C & AG 2007). This may act as an
incentive to do more public work as the more public work which is done the more private and better paid work that can be undertaken.

To make a comparison between the public and private sectors we first examine at the payment schemes for surgeons in both sectors and question whether there is in place any incentive which might encourage clinicians to behave differently in one sector than in the other. Many surgeons have a public salary which is enhanced by private practice either carried out in the public hospital or done at a private facility. All surgeons agree that they are well paid for their work but in the public side of the practice there is little incentive to be especially productive:

‘…..pay in the public sector was in the form of a fixed salary so that productivity was not an issue but the main focus of the effort was care of the patient’ (Surgeon S4).

However, surgeons in the public sector are required to maintain a ratio between the number of public and private operations performed in public hospitals:

‘I personally think that the way I have it, a balance of public and private, where I keep my ratios fairly steady, but the harder I work in the private side the harder I work in the public side and I gain, the public service gains and there is a nice symbiosis’ (Surgeon S3).

The current contract allows for 20 per cent private work and up to 30 per cent in certain circumstances (Mulholland 2011). When it comes to private work the fee paid to the surgeon is the same no matter who the payer is and therefore the choices made by surgeons as to whether they operate on a patient in a public hospital or a private one relate to the judgement as which location has sufficient back-up in equipment, personnel and other facilities to ensure the optimum outcome. Surgeons feel that they are sufficiently well paid to be able to ignore any potential financial incentive which might cloud their clinical judgement:

‘On a day to day basis I don’t think of economic issues and if I give quality of care, funding takes care of itself’ (Surgeon S5)

This may well be the case for many surgeons but recent studies of motivation crowding effects have shown that for well-paid researchers, even small financial
incentives can make a great difference, if the incentives are perceived to be supportive (Andersen and Pallesen 2008). It is probably worth noting however that the term ‘well paid’ in the context of Danish researchers amounts to €60,000 per annum (Academic Careers Observatory 2011). Irish orthopaedic surgeons receive a salary in the public service of at least €173,000 and most would be able to make the same amount again on private practice (DoH 2011). It is not unusual for consultant surgeons to earn annual salaries of €500,000 and at least one earned €1 million in one year from payments from the VHI alone (O'Regan 2011a, Hunter 2011). Extra payments at this level of salary may still have the incentive to motivate as much as a score card of achievement as for the money.

In any case ethical training in medicine together with professional bodies and overseeing by the Medical Council gives rise to a culture where most surgeons interviewed state that helping patients and giving good care and attention are the overriding motivations in their work. Clearly they would be unlikely to say otherwise but hip replacements in particular are very successful operations in the majority of cases and doctors receive a great deal of praise and gratitude from their patients. This is striking when compared to oncology, cardiology or neurosurgery:

‘You can hugely improve their lives in an hour and a half operation it can change somebody’s life’ (Surgeon S9).

Not surprisingly the overall job satisfaction in this sub-speciality is expressed by all surgeons interviewed as is a high degree of pride and belief in their ability to do as good a job as it is possible to do.

5.5 Methodology

In Ireland there is a lack of reliable quantitative data to augment the interviews. Much of the quantitative data we need in pursuit of this study relating to public hospitals has been sourced from the ESRI and its Hospital In-Patient Enquiry Scheme (HIPE). HIPE is a system designed to collect demographic, clinical and administrative data on discharges and deaths from hospitals nationally and has been
in existence since 1969. Consumer satisfaction can be measured from ‘Insight 07, Health and Social Services in Ireland’ - a survey of consumer satisfaction (Boilson et al. 2007) commissioned by the HSE and carried out by a group from University College Dublin (UCD) and Lansdowne Market Research. The average length of stay in public hospitals was sourced from the ‘Activity in Acute Public Hospitals in Ireland, 2009 Annual Report’. Satisfaction rates for public patients treated under the NTPF in private hospitals were taken from the NTPF’s Patient Satisfaction Surveys.

No such publically available information exists for the private sector. This comparative information was gathered by the author's survey together with ‘Patient Satisfaction Surveys’ from the NTPF and individual private hospital Patient Satisfaction Surveys.

Raw statistics can tell us only so much. For example, we are reliant on individual units to report on themselves and therefore published material is likely to reflect positively on those who produce it. For greater insight into organizational behaviour and performance we rely on qualitative data obtained by interviewing consultant orthopaedic surgeons and hospital managers.

We interviewed twelve subjects. Nine were semi-structured interviews with surgeons. The questions posed to the surgeons were the same as those posed to the Danish surgeons which were kindly provided by Dr Mads Jakobsen, co-author of the Danish study (see Appendix G). The question list was enhanced somewhat to make up for the lack of information readily available on the private sector and to reflect differences in the Irish system. The interviews were transcribed and coded into the software ‘NVivo’ using the same nodes as those used in the Danish study. The total size of these interviews is approximately 100,000 words.

As previously described most Irish surgeons operate in all sectors locally available to them. Three surgeons interviewed worked in public hospitals where they also carried out private work. Two surgeons worked in private practice only but had previously worked in the public system and thus felt qualified to comment on both sectors. The other four worked in in both public and private facilities and carried out private work in all locations.
The surgeons were selected initially from the membership list of *The Irish Institute of Trauma & Orthopaedic Surgery*. We examined the websites of hospitals where hip replacements were carried out to identify the consultants who specialize in this procedure. These surgeons were contacted through their secretaries and with a follow-up email setting out what the study was about. In some cases we used the snowball method of asking the interviewee if they could recommend a colleague. The other interviews consisted of three general interviews with hospital CEOs. All participants, both interviewees and institutions, were guaranteed anonymity and no reference is made to individuals by name in this thesis. Institutions are referred to in a general way but no specific data is attributed to any individual institution. Some relevant geographical anomalies were noted during the interviews, but these could not be discussed as to do so would clearly identify the participant.

Reflecting the methodology of Andersen and Jakobsen (2010), the interviews were coded to the theoretic categories of specific aspects of the questions we wish to study, such as patient selection, professional norms, motivation and behaviour of surgeons.

We have used a matrix display of statements comparing public and private clinics on the question of patient selection (see Table 5.4). Generally we use selected direct quotations within the text to reflect the common trends which emerged. Few anomalies occurred and some interviewees gave surprisingly candid answers where it might not have been expected, which we detail below. All of the interviewees were busy people and gave their time willingly, motivated by a duty to assist an academic study. No one was remunerated for their time.

### 5.5.1 Credibility and validation of findings

All transcripts were examined to ascertain the credibility of the statements and were subjected to source evaluation. The remarkable consistency of some themes gave extra validation to their legitimacy. For example, the issue of the similarity of the fee schedule of all insurers and the NTPF. Some questions were inquiries of a factual nature such as how payment was structured in the private sector. If nine surgeons out of a potential 40 state that it is on the basis of ‘fee per item’ then we can accept that it is the case and can be generalized to the profession as a whole. There is little
reason to believe that there are profit-sharing incentive schemes which have not come to notice.

On the other hand questions about an individual’s motivation are in a different category. We can expect from the way that the question was posed that most interviewees will say that care of their patient was their most important consideration. One actually said that he was motivated by the money but generally the pay levels are settled and are likely to be a ‘hygiene issue’, that is, a benefit which goes with the job but does not specifically act as a motivator (Herzberg 1968).

We can suspect that, in common with the rest of humanity, care of their patients as a motivation may be adversely affected if pay levels were dramatically reduced. We fully acknowledge that interviewees have every incentive to put their contribution and that of their profession in the best possible light and that the full truth of the situation may not come readily from their lips. We acknowledge that this could be viewed as a source of bias. However the questions were designed in a way to elicit behavioural standards without facing the interviewee with direct yes/no questions. A table with the NVivo codes, sub-codes and description can be seen in Appendix E.

The questions we must ask in relation to credibility and validation are: Are the answers plausible? Are there motivations to falsify answers? Are answers corroborated by the other interviewees? Colwell et al (2002) argue that using semi-structured interviews allows for the examination of each discrete questioning phase which increases the predictive accuracy. Occasionally, interviewees made statements which did not reflect what was being said generally, such as the statement on motivation mentioned above. These are noted as interesting asides but not taken as factors which can be taken into account as findings. Findings from the qualitative interviews are extracted from the homogenized answers given by surgeons to a series of questions in a specific order which were asked to all participants. A full list of the questions posed to the surgeons is in Appendix G. The sample size must be seen in the light of the population of the country and the number of orthopaedic surgeons which work in that population and the number of professionals who specialize in this particular procedure. When the questions posed to the surgeons are examined it is easy to see that further sampling would bring little in the way of new information as
much of the professional behaviour of the surgeons had been explained (Bowen 2008). In this project we are scrutinizing the dynamic qualities of the surgeons’ situation as a way to analyse the issue of ownership and so the issue of sample size has little bearing on the logic of the study (Crouch and McKenzie 2006).

5.6 Findings and Analysis

At the outset of this chapter, we asked the following questions:

- Do the two sectors behave differently in the way they select their clients?
- Are the patients subjected to different standards of treatment depending on which service they choose or are compelled to use?
- Are the clinical results better in one sector that the other?
- Are users of the service more satisfied in one sector over another?

We can now use the data gathered to answer these questions.

5.6.1 Patient Selection

The issue of patient selection in the case of public patients is simple: they are compelled to have their procedure in a public hospital unless an arrangement similar to that of the NTPF is made so that they could go to a private hospital.

Patients who either fund their treatment via an ‘out of pocket’ payment or through their private health insurance, that is private patients can, potentially have their treatment carried out in a public hospital or a private one. This decision will be made by the consultant surgeon, possibly with some input from the patient and/or family members. In this way we can say that the public and private sector do behave differently in the way they ‘select’ their clients. However, with regard to those who have a choice – private patients – we have to pose the question: is there an economic motivation for choosing one location over another? Those who have the ability to choose can in the first instance choose their GP, who in turn may recommend a consultant, who then may choose the hospital in which to perform the operation and will also choose the type of prosthesis.

There is little evidence of explicit trade-off between economic considerations and good medical practice in the case of hip replacements. Clinical decisions seem to be made in the best interest of patients bearing in mind the structural and institutional
framework in which they are made. The professional autonomy maintained by consultant surgeons, historically and in the present, most likely has an influence on this. There is little significant clinical impact as a result of ownership of the facility. The autonomy of the consultant surgeons, and their choice of location in which to operate on any individual patient, ensures that economic factors do not impact on the quality of treatment. The quality of facilities both within the public hospital sector and the private hospital sector are not consistent and therefore in some areas the public facility is better equipped to deal with complex cases than the private and in other areas it is the reverse.

Conceivably, surgeons could make the choice based on which option would maximize their fees but the evidence of a virtual oligopoly operating with the payers makes this unlikely. All surgeons stated that the choice of clinic in which to operate on a patient, who had the option, was based solely on clinical considerations. Some private clinics do not have intensive care or a cardiology units as back up and therefore would not be suitable for certain classes of patient. It is fair to conclude that the selection of patients by private clinics is not on the basis of economic considerations as surgeons make the decision on the basis of which location will likely give the optimum outcome for the patient.

The market exists for people who are wealthy or well insured. These people have a choice where they get their treatment. For the public (poorer) patient long waiting times and less medical attention often gives rise to more complex and less treatable joint deterioration:

‘.....the more challenging work is often the more public work in terms of what I do. I do hip and knee revision and the more challenging cases are always more public almost never private......because the public are so badly serviced they get so completely wrecked that by the time you get to them they are destroyed and they are difficult cases’ (Surgeon S7).

Their treatment however, when they can access it, is the same whether in the public system or in a private clinic.

It may be assumed that private hospitals engage in cream skimming. That is, favouring patients who have some characteristic other than their need for care, which enhances their profitability. That is assuming that hospitals rather than surgeons have
the choice of patients. This would involve taking in less ill patients whose treatment would have a lower cost for the standard reimbursement and therefore would be more profitable. If the market for hip replacements was open and covered the entire population and all types of hospital had equal access to the market this question could be examined. We can conclude that some private clinics treat patients with the less complicated surgical requirements and there are a number of reasons for this but there is no evidence that it is connected to the search for profits. It must also be stressed that there are private clinics which pride themselves on being capable of undertaking the most complex cases.

As already stated, surgeons have pointed to more complex cases and greater comorbidities in public patients. This is due to the lack of service and long waiting times experienced by poorer people. Therefore with the exception of patients who had been referred to private clinics during the era of the NTPF the private clinics would have been unlikely to see these patients. Private clinics eagerly welcomed business from the NTPF. The surgeons maintain strict autonomy over where they will treat their private patients in consultation with the patient or their relatives and so the choice will be made on the basis of the facility’s ability to deliver a safe outcome:

‘I decide which patient gets operated on in which hospital and it’s my decision it’s not necessarily the CEO of the hospital, who doesn’t have anything to do with that decision but the fact that they don’t have an intensive care unit is a factor’ (Surgeon S9).

One surgeon suggested that the nurses in the public hospitals tend to be more experienced and better able to handle complicated cases or difficult situations. It could be suggested that by keeping equipment and back-up facilities at a more basic level private clinics compel surgeons to de-select the more complex cases in favour of the public hospital. However the private hospitals which have made the big investments required to provide ‘state of the art’ facilities are the ones which are producing greater profits as can be established from annual reports. Because the decision on patient selection is not in the hands of the private clinics’ management and extra costs are partially recoupable in any case we can conclude that cream skimming is not a practice likely to be widespread in the private sector.
Table 5.4: Statements on selection of patients from surgeons

<table>
<thead>
<tr>
<th>Statements about</th>
<th>Surgeons who work in a Public hospital with private work</th>
<th>Surgeons who deal in Private practice only</th>
<th>Surgeons who deal in Public and private practice in both public and private hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public clinics</td>
<td>…the more challenging work is often the more public work in terms of what I do. I do hip and knee revision and the more challenging cases are always more public almost never private. (S7)</td>
<td>In terms of what I do for them, what operation I do, what implant I select there is no difference at all. I would say there are some people say with a heart problem, if he’s a private patient I am always going to steer him down to the Private (Name) Clinic because they have a great cardiac service there. (S6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>…my operating list could get cut next week because the HSE tell me that they don’t have enough money anymore and so I can’t do any more work. (S7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private clinics</td>
<td>… are there some patients which wouldn’t be suitable? Yes! It’s back-up, it’s equipment, it’s technical, it’s expense sometimes the more technical operations, if you take the orthopaedic implants, if you like, they can be quite a bit more expensive in certain situations and then you’ll have patients who are medically higher risk and need intensive care. Now increasingly the private hospitals have beefed up their ancillary stuff, a lot of them have cardiology on site a lot of them have intensive care units so increasingly that’s less of a problem. For many years they would have only done primary operations which are considerably cheaper and less technically demanding and less complex implants. (S2)</td>
<td>In the private sector we tend to do one or two half-hour sessions with an actual physiotherapist, before they come in. In the public sector they get about fifteen minutes. (S6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>… it would not be safe to treat a haemophiliac or someone who had a history of heart trouble because the multi-disciplinary personnel and facilities that would be required would not be available at the private clinic and so would have to be done in a major public hospital. (S4)</td>
<td>The private hospital that I work in doesn’t have an intensive care unit so if a patient needs intensive care post operatively they can’t be done in the private hospital. I decide which patient gets operated on in which hospital and it’s my decision it’s not necessarily the CEO of the hospital, who doesn’t have anything to do with that decision but the fact that they don’t have an intensive care unit is a factor. (S9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>We have excellent facilities compared to regional orthopaedic units. I get patients sent to me who are too medically unwell for treatment in the public facility. This was the reverse in the past. (S5)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

140
Reimbursement for all private work whether done in a private hospital or a public one appears to be the same. Costs associated with public patients in public hospitals are monitored by Casemix Ireland. Casemix is an internationally recognized system which monitors health services. It compares activity and costs between hospitals by classifying hospital data into groups called DRGs (Diagnosis Related Groups), which are clinically similar and consume similar resources (Casemix Ireland 2011). This service allows hospitals to measure their productivity. The average cost of a hip replacement operation in a public hospital is €10,931 (Casemix Ireland 2013). As the NTPF negotiated similar prices for their patients we can assume that the VHI and other insurers would ensure that the same criteria applied in private hospitals. This must have a bearing on the fees negotiated with the main insurance companies which, as we have seen, are remarkably similar. The fee paid to the surgeon is the same in all hospitals for the same DRG procedures there is no incentive for a surgeon working in a private hospital to deselect patients on economic grounds. As the hospital allows the surgeon make the decision there is no economic basis for the choice. One hospital CEO suggested that they win on some and loose on others:

‘Well we have to look at what’s best for the patient at the end of the day because we are making a judgement based on the patient coming in at the time and it may take a bit longer so it’s an average’. (CEO 3)

If a patient becomes unexpectedly sick and is detained in hospital for a longer period, then the hospital can bill the insurance company or whoever the payer is for the extra costs. The surgeon’s fee remains the same:

‘If somebody gets sick and spends much longer in hospital than you would expect they write you and ask you to explain why this and why that and that’s.....and I don’t know what happens then. I’m not privy to how they sort out the bill with the hospital. I presume the hospital accountant will send a bill to the VHI but no matter what happens my fee is the same’ (Surgeon S9).

Once the selection is made the question shifts to the consistency of the standard of treatment given to patients from whatever source they come from. Public patients do not have a choice – they are dealt with in the public sector. Those on waiting lists and those who have private health insurance or those who pay directly can make comparisons between the two sectors.
5.6.2 Standards of Treatment

With the autonomy of the surgeons regarding where they operate, what equipment and what implant they use established, there is very little room to suspect that private clinics are in a position to put economic considerations above clinical choices even though they have a greater incentive to do so to increase profits and ensure survival. Private clinics also have a reputation to maintain and even if they were minded to maximize profits in the short term it would not give them long term benefit. Indeed a number of surgeons suggest that it is in the HSE hospitals where there is greater pressure to re-examine practices to see if cost savings can be made. The cost of hip implants ranges from €1,029 to €17,188 (C & AG 2010).

All hospitals are paid a flat fee by insurers for the operation and accommodation is paid on a per diem basis. The finding on this issue is that expensive implants obviously have an impact on the profitability of a private clinic’s business and on the use of funds granted to a public hospital but there is no evidence of excessive pressure comes from management which would override a surgeon’s clinical opinion on what is required in any given instance. There is an increased appreciation on the part of surgeons of the need to justify the use of higher cost implants and be cognisant of the prevailing financial position of the health service. Equally, managers appear to be reluctant to force change in an area where the professional medical personnel have superior knowledge.

Another area in which hospital managers in both sectors could be suspected of attempting to put economic considerations ahead of clinical concerns is in the selection of the implants. With such a wide variation in prices for hip implants this has got to be a consideration in the organization and planning the prudent use of available funds. As we have seen the choice of implant is dependent on the surgeon’s opinion of what will work best in any given situation and also what the surgeon is comfortable with as a result of his training. A hip replacement performed on a person under 50 years is likely to need revision within the patient’s lifetime and so the type of operation and implant will be different to the type given to somebody in their 80s. The cost of the implant is not necessarily directly related to quality or longevity:

‘….the cheapest one isn’t always the worst one and the most expensive one isn’t always the best one’ (Surgeon S9)
5.6.3 Quality Measures – Length of Stay

The determinants of performance in the public and the private sectors are usually different. Private sector performance is judged by balance sheet and profit and loss account. The public sector is judged by certain aspects of performance such as quantity and quality of output, efficiency, equity, value for money and consumer satisfaction (Boyne 2003). When viewing the contrast between public and private delivery of state sponsored services like health then we must accept that the economic wellbeing of private firms is a matter for themselves and what concerns society are the same measures that are applied to the public sector. The difficulty with this is that there is little agreement on the determinants of performance. Boyne (2003) studied evidence from sixty-five empirical studies on the determinants of performance for public service and concluded by pointing to the paucity of existing evidence.

In attempting to measure these issues in relation to hip replacements there are a few markers which can be examined. Inpatient length of stay (LOS) has been used by numerous authors over the years as a proxy measure of efficiency in health services due to the insufficiency of data on costs (Cooper et al. 2010, Fenn and Davies 1990, Martin and Smith 1996, Ellis and McGuire 1996, Gilman 2000, Norton et al. 2002, Siciliani et al. 2012). Shorter inpatient LOS could be viewed as a cost cutting measure (see Tables 5.5 and 5.6). However the length of stay after major surgery has to have a certain minimum if the providers of the service are not to cause future problems requiring re-admissions and even greater costs. Most surgeons are driven by certain protocols where there is a recognized norm for length of stay. This norm is equally recognized in both the public and private sectors. This norm cannot easily be shortened but could be lengthened if the circumstances demand it:

‘We have a standard discharge policy which all of the orthopaedic surgeons have signed off on and the standard policy is that as things stand at present patients are admitted the day prior to surgery, for joint replacement surgery, and are discharged day six. Therefore if they come in on a Monday they go home on a Monday and it means that we can turn around one joint replacement per bed per week using that system. So that is a default system and patients will only stay longer than that designated six days post-operatively if there is a problem identified which occasionally happens’ (Surgeon S3).
Table 5.5: Number of procedures and length of stay for Hip Arthroplasty patients in Public Hospitals in Ireland

<table>
<thead>
<tr>
<th>Hip Arthroplasty</th>
<th>15 – 44 Years</th>
<th>45 – 64 Years</th>
<th>65 Years and Over</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Procedures</td>
<td>169 (4%)</td>
<td>1,199 (25%)</td>
<td>3,345 (71%)</td>
<td>4,714</td>
</tr>
<tr>
<td>Average Length of Stay (Days)</td>
<td>6.8</td>
<td>8.1</td>
<td>11.2</td>
<td>10.2</td>
</tr>
</tbody>
</table>

Source: (ESRI 2009)

Most surgeons state that they are the decision makers regarding when a patient is discharged but some state that the nursing staff may discharge the patient if after the dressings come off and no infection is present and the patient is able to perform certain actions unassisted such as walking a length of corridor or going up and down stairs. Table 5.6 shows that the length of stay in private facilities are shorter than those in the public hospitals but this may reflect the predominance of less complex cases in the private sector due to reasons suggested above.

Table 5.6: Comparison of length of stay between public and private hospitals for hip arthroplasty

<table>
<thead>
<tr>
<th>Hip Arthroplasty</th>
<th>Average length of stay (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>10.2</td>
</tr>
<tr>
<td>Private Hospitals</td>
<td>7.7</td>
</tr>
</tbody>
</table>

Sources: (ESRI 2009); Author’s Survey

5.6.4 Clinical Results

Other measures of the clinical results used in the Danish study included percentages of acute re-admissions of patients within 30 days of discharge for elective hip replacement and a measure of patient satisfaction. Total re-admissions in the public hospital system for hip arthroplasty in 2009 amounted to 2.8 per cent (direct author data request to HIPE) (hospitals, n=18) but higher in the private sector at 3.9 per cent (hospitals, n=4) as shown in Table 5.7. Taken with the higher incidence of more complex cases the reverse might have been expected but this may have been modified by the slightly longer stay in the public hospitals. It is also worth noting that figures for the public hospitals only captures continuation of treatment in the
same hospital and those readmitted to a different hospital will not show up as readmissions. Therefore the figure may underestimate the true level of re-admission.

**Table 5.7: Number of inpatient readmissions for hip Arthroplasty 2009**

<table>
<thead>
<tr>
<th>Total Readmissions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip Arthroplasty</td>
<td>2.8%</td>
</tr>
<tr>
<td>(Public)</td>
<td></td>
</tr>
<tr>
<td>Hip Arthroplasty</td>
<td>3.9%</td>
</tr>
<tr>
<td>(Private)</td>
<td></td>
</tr>
</tbody>
</table>

Sources: (ESRI 2011b); HIPE Unit, Health Research and Information Division, ESRI; Author’s Survey

As mentioned above, hospitals’ average length of stay (LOS) has been used by numerous authors as a measure of efficiency. LOS for public and private hospitals at 10.2 and 7.7 days respectively is relatively long in any case. It must be noted here that the figure for public hospitals is the total number of hip replacements which includes emergency admissions and some with ‘Catastrophic Complication or Comorbidity’. These cases are unlikely to turn up in the private sector where all the cases would be elective. The LOS figure in the public sector when these cases are removed is 8.88 days (Casemix Ireland 2013). The American Academy of Orthopaedic Surgeons suggest that a hospital stay of 4 to 5 days is the average for traditional hip replacement (AAOS 2007). In the British NHS the average LOS is 4.5 days for private operators and 7.5 days in the public system (Siciliani et al. 2012). Cooper et al, (2010) using figures over a longer time frame gives the average LOS as 7.9 days suggesting that there has been an improvement in efficiency in the NHS. We could draw the inference that longer average stays are not connected to re-admissions and might be a function of poor bed management, loose cost control and the possibility that surgeons do not work at weekends in public hospitals and patients who are ready to leave on Friday must wait until Monday to be discharged.

5.6.5 User Satisfaction

‘Insight 07’ was an independent study of consumer satisfaction with Health and Social Services in Ireland which was commissioned by the HSE (see Table 5.8). To get a view of satisfaction levels in the private sector we must look at individual hospitals’ Patient Satisfaction Surveys published on their websites. The limitation on
this type of information is that satisfaction surveys, whether done by rigorous academic discipline or clinics’ own websites have data which has been submitted voluntarily by the consumers of the service. This means they may be filled out with extra care by people who have strong views one way or another. Views expressed will also be coloured by the circumstances of the patients. For example, popular websites would suggest that maternity hospitals have a low rating for hygiene: post-natal patients may notice these things more than those in geriatric wards. The NTPF also produced quarterly Patient Satisfaction Surveys (see Table 5.9) on all the private hospitals they used and when taken together with individual surveys convey a good picture of consumer opinion as far as it can be established.

Table 5.8: *Inpatient’s ratings for quality of care and cleanliness while in public hospital*

<table>
<thead>
<tr>
<th>Group</th>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Very Poor</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 50s Care</td>
<td>19%</td>
<td>37%</td>
<td>31%</td>
<td>9%</td>
<td>2%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Over 50s Care</td>
<td>33%</td>
<td>40%</td>
<td>18%</td>
<td>6%</td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Under 50s Cleanliness</td>
<td>22%</td>
<td>35%</td>
<td>25%</td>
<td>7%</td>
<td>5%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Over 50s Cleanliness</td>
<td>28%</td>
<td>44%</td>
<td>14%</td>
<td>7%</td>
<td>3%</td>
<td>3%</td>
<td></td>
</tr>
</tbody>
</table>

*Source:* (Boilson et al. 2007) – 3517 Respondents

Table 5.9: *Consolidated satisfaction survey of NTPF patients, 2009* for private hospitals

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Poor</th>
<th>Number of Surveys returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aut Even, Kilkenny</td>
<td>80%</td>
<td>16%</td>
<td>4%</td>
<td>0%</td>
<td>418</td>
</tr>
<tr>
<td>Beacon Hospital, Dublin</td>
<td>80%</td>
<td>16%</td>
<td>4%</td>
<td>1%</td>
<td>458</td>
</tr>
<tr>
<td>Blackrock Clinic, Dublin</td>
<td>79%</td>
<td>17%</td>
<td>4%</td>
<td>1%</td>
<td>571</td>
</tr>
<tr>
<td>Galway Clinic</td>
<td>75%</td>
<td>21%</td>
<td>4%</td>
<td>1%</td>
<td>779</td>
</tr>
<tr>
<td>Hermitage Clinic, Dublin</td>
<td>69%</td>
<td>25%</td>
<td>5%</td>
<td>2%</td>
<td>301</td>
</tr>
<tr>
<td>Mater Private, Dublin</td>
<td>75%</td>
<td>21%</td>
<td>4%</td>
<td>0%</td>
<td>1529</td>
</tr>
<tr>
<td>Shanakiel Clinic, Cork</td>
<td>90%</td>
<td>8%</td>
<td>2%</td>
<td>0%</td>
<td>176</td>
</tr>
<tr>
<td>Sports Surgery Clinic</td>
<td>82%</td>
<td>18%</td>
<td>0%</td>
<td>0%</td>
<td>22</td>
</tr>
<tr>
<td>Whitfield Clinic</td>
<td>88%</td>
<td>12%</td>
<td>1%</td>
<td>0%</td>
<td>219</td>
</tr>
</tbody>
</table>

*Source:* (NTPF 2011) * NTPF statistics are produced per quarter
Like the Danish study we can expect satisfaction to be greater in the private sector than in the public due to non-clinical aspects of the treatment such as the ambiance, exclusivity and in the belief that they are getting a better service because the clinic has every motivation to enhance its reputation.

Patients choosing private hospitals are likely to be in a higher socio-economic group and may have a greater level of social capital with which to counteract feelings of dissatisfaction sometimes felt during a period of illness. They are also the group who have a choice as to where they will be treated and will most likely have less criticism about the facility they chose as opposed to those who have no choice and must contend with whatever they get. We find that patient satisfaction levels are greater for private facilities but there is nothing to suggest that clinical quality or outcomes have any bearing on this finding (see Table 5.10).

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Very Poor</th>
<th>Don’t Know</th>
<th>Excellent</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>26%</td>
<td>38.5%</td>
<td>24.5%</td>
<td>7.50%</td>
<td>2%</td>
<td>0%</td>
<td>1.5%</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>79.5%</td>
<td>17%</td>
<td>3%</td>
<td>0.5%</td>
<td>0%</td>
<td>0%</td>
<td>99.5%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: (Boilson et al. 2007); (NTPF 2011)

5.7 Conclusion

In this chapter we have examined aspects of hip replacements in both the public and the private hospitals sectors to answer the question whether ownership affects the delivery of professional health services in Ireland. Is the fact of ownership, whether in public hands or private, a deciding factor as to the quality of service and the behaviour of professionals in the execution of their duties? In viewing public services generally the theoretical argument put forward by Andersen and Jakobsen (2010) is that public clinics face more political involvement than private clinics and so private clinics have more autonomy and more credible reimbursement schemes than public ones. We could also add that private businesses usually have a clearer
command structure and a clear objective function. Some of the activities undertaken in public hospitals, such as teaching, are not measured when making comparisons. Moreover very large organizations with multiple site institutions and a variety of historically evolved cultures are unlikely to be as nimble in pure business terms as a more recently set-up, single unit establishment which has a limited menu of services.

Using the restricted amount of quantitative data available greatly enhanced by the interviews and following Andersen and Jakobsen, we have examined how ownership affects incentives, patient selection, clinical procedures, clinical performance and non-clinical factors bearing in mind the differences between the Irish system as it is currently structured and the Danish system.

Our first finding: Clinical decisions are taken by surgeons in consultation with other health professionals no matter which sector they happen to be working in. For the most part, these decisions are made in the best interest of the patient with little evidence of any trade-off between economic considerations and good medical practice.

This is in some way due to the strongly held position of professional autonomy maintained by the surgeons. The professional organization of the orthopaedic surgeons and the governance of the Medical Council ensure that Irish surgeons are trained to the highest standards and that training is kept up to date. Managers in both sectors seek methods of reducing waste and excessive spending. Surgeons take economic issues into consideration provided that it doesn’t have an adverse effect on the best outcome for the patient. Many surgeons suggest that their level of autonomy may not survive indefinitely (see figure 5.3).

Our second finding is that the professional norms of surgeons has a major bearing on behaviour, not that there appears to be any wish on the part of hospital managers or CEOs to interfere with their autonomy in clinical matters. Some private clinics do a greater amount of straight-forward uncomplicated work when compared to their public counterparts. But in most cases this is as a result of the choice made by the surgeon and very often that is based on the availability of back-up emergency services, equipment and personnel. The better equipped, staffed and funded private hospitals are in a position to compete for complex work with any public hospital and these are the clinics which appear to be most profitable. Also the prices commanded
from the various payers are the same. Therefore it can be concluded that cream skimming does not occur as a commercial weapon and that private clinics rely on non-clinical factors to attract patients. This is also attractive for surgeons as it gives them more options to treat their patients and they can do far more private work than they might be able to do with the ratio limit they have for private work in the public hospital. There is also a group of surgeons who work exclusively in the private sector. Some of these have been well established in the public system but have retired due to the frustrations associated with working in the public system. Frequently their operating list can be cancelled at short notice due to other factors in the public hospital. These surgeons are now in a position to devote all their time to operating in the private hospital and all of their patients will be treated in that hospital. Professional norms of the medical personnel, as well as the pursuit of profits, will ensure that the private hospitals which will survive into the future will be the ones to that have the very highest standards of equipment and personnel and will be able to compete with any public hospital.

Our third finding is Standards of treatment are the same for all patients. The difficulty in the Irish system is the route to getting treatment in the first place. We have seen that some sections of the community are poorly served by the present system and enter treatment with the severe disadvantage of having had to wait for a much longer time than those who are financially better off. Clinical results and testament from the surgeons bear this out. Clinical results, when put against international comparison, suggest that both sectors in the Irish system could increase efficiency but work practices in the public sector in particular, including those of the health professionals, would need to be dramatically altered.

The findings of this chapter have limitations when consideration is given to the massive public undertaking that is the Irish Health Service and then the small and fairly new for-profit sector of private hospitals. The availability of data from a national register is limited when compared to the system in Denmark and other Scandinavian countries. Ireland is not unique in this regard. Many countries are only beginning to copy the Scandinavian model now in response to public anxiety caused by faulty implants used in the recent past (Lakhani 2010). In contrast to the public sector there has been no data up to now for private hospitals with which meaningful
Comparisons could be drawn. The author’s survey of private hospitals together with the interviews involving surgeons and hospital managers provides a new insight into how this particular treatment is organized in Ireland. The existence of this study alongside the original in Denmark has reinforced the point that professional norms among medical personnel act to modify overt commercial considerations taking precedence and if further studies are carried out in other European countries it may emerge as a function of the medical education system (see Table 5.11 for summary).

Ireland is at a crossroads as regards the organization of its health services. There is room for both public and private hospitals within a universal health system based on insurance. If public hospitals are made into individual trusts competing with each other for business how will that impact on the teaching and university hospitals? If all perverse incentives are removed from the system where the community, irrespective of the income, have a choice of speedy treatment on the basis of need
and surgeons are free to do both public and private work we may develop a real functioning market in the provision of services like hip replacements.

Table 5.11: Summary of findings to the questions posed

<table>
<thead>
<tr>
<th>Questions</th>
<th>Public Hospitals</th>
<th>Private Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Selection</td>
<td>Public hospitals have no choice regarding patients selection except for the possibility of allowing a patient to wait so that they can be treated by the NTPF</td>
<td>The orthopaedic surgeon is autonomous in who gets treated in what hospital. Selection or de-selection from a private hospital is due to levels of back-up thought appropriate in each case</td>
</tr>
<tr>
<td>Standard of Treatment</td>
<td>Clinical treatment is identical in both sectors</td>
<td>Clinical treatment is identical in both sectors</td>
</tr>
<tr>
<td>Clinical Results</td>
<td>Measured by length of stay and re-admission levels there is little difference although public patients have a greater tendency towards co-morbidities</td>
<td>The public patients treated by private hospitals through the NTPF may have the effect of evening out clinical results</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>Declared patient satisfaction is less in the public sector. But public patients have greater co-morbidities and may have less social capital to cope with illness and with asserting themselves in the face of medical professionals</td>
<td>Declared patient satisfaction is greater in private hospitals. Private patients have, by definition, higher income and are likely to have more education and the choice between both sectors. Having made the choice are likely to be happy with it</td>
</tr>
</tbody>
</table>
Chapter 6:

Does ownership affect the provision of health services in Ireland? - The Case of Cataract Operations in Public and Private Clinics

Elective surgical treatments are carried out in both public and private clinics in Ireland. The ability to pre-plan their execution and the relative lack of complication involved makes them an ideal way to make comparisons between the public and private sectors. The comparison is made through the view of consultant surgeons operating in these sub-specialities and offers a unique assessment of the merits or otherwise of each sector.

This chapter builds on the results from our study of the effects of ownership on the provision of hip replacements by applying the same technique and methodology to another commonly carried out procedure – namely cataract extraction operations. Using the background of the 12 interviews from the last chapter and adding a further 7 specifically with ophthalmic surgeons we get a distinctive insight into the organizational behaviour and performance of this sub-specialty and examine whether or not ownership has an impact on quality, outcomes or professional behaviour.

Similar to the study of hip replacements in Chapter 5 we now pose the same questions in the case of the cataract extraction operation:

- Do the two sectors behave differently in the way they select their clients?
- Are the patients subjected to different standards of treatment depending on which service they choose or are compelled to use?
- Are the clinical results better in one sector that the other?
6.1 Introduction

The purpose of this chapter is to examine the organizational behaviour and performance of ophthalmic surgeons who work in the public and private sectors in Ireland and ask the question: does ownership of medical or surgical facilities have an
effect, either beneficial or detrimental, on the provision of and the outcomes to cataract extraction operations? Cataract extraction operations are the most common elective procedures and are performed in great numbers in both the public and private sectors. In 2009 the number of lens extractions carried out in Irish public hospitals was 8,911 (ESRI 2011a). The OECD reports that 10 per cent of hospital activity in Ireland takes place in private hospitals which suggests that close to 10,000 cataract operations are carried out per year (OECD 2011). The closest rival in numbers among all the available procedures is hip replacements of which 4,664 were carried out in public hospitals in 2009. There are similarities in the provision of cataract surgery to the provision of hip replacements (see Chapter 5) in that both procedures are generally elective and therefore can be planned in a methodical fashion and so make good instruments with which to compare the two sectors by ownership profile. One of the chief differences between hip replacements and cataract extractions is that the cost of implants. In cataract surgery the cost of the implant is not currently an issue which has a big impact on the final cost whereas in the case of hip replacement the cost of the implant, at the surgeon’s discretion, can significantly alter the economics of the case.

6.1.1 Background
There is growing recent evidence that competition in hospitals can lead to improvements in hospital quality (Cooper et al. 2011, Kessler and Geppert 2005). Earlier studies however, found the relationship between competition and quality to be a negative one (Propper et al. 2004). Others have demonstrated that the introduction of competition to areas like health care have a negative effect on equity (Dixit 2002, Le Grand and Bartlett 1993, Boyne 2003). Evaluation of any kind of performance depends on what criteria and principles are used to make that evaluation. Commentators may arrive at these cases with a set of conditions which will predetermine the outcome. Eggleston et al (2008) did a systematic review of studies into the relationship between ownership and quality in American hospitals and concluded that ownership was not systematically related to differences in quality. Most studies used mortality rates or rates of adverse events as a measure of quality but the review found that results depended on data sources, time period and region covered as there was a great diversity in the findings and no definitive answer.
to the question. This may suggest that many studies get the results that they expect and the design impacts the result. Moreover, what constitutes quality may vary from study to study. Improvements in welfare in society tend to drive the allocation of resources. Health care together with other competing needs may demand greater use of resources without the ability to deliver what constitutes the greatest increase in welfare. Some investments in health may deliver great benefit to a small group but may not improve the health of the population as a whole. Quality in health care incorporates many separate characteristics which are not all in tandem. For profit maximizing firms in health care it may be tempting to distort or manipulate the accessibility to their services to attract a mix of patients who will be most profitable (Eggleston et al. 2008). A similar study reviewing the diverse findings of the relationship between ownership and financial performance found that as a general rule, for-profit hospitals made more profit but no evidence supported the proposal that they were more efficient (Shen et al. 2007).

6.1.2 Budget Constraints and Incentives
In the previous chapter we have pointed to the different motivations in the public and private sectors. Much literature suggests that the principal dividing line between the two sides is the existence of soft budget constrains (SBC) in the public sector and hard budget constrains in the private (Stiglitz 1991, Duggan 2000). Firms in the private sector that consistently fail to perform, financially, will go out of business. A similar situation in the public sector may result in support from government. The concept of SBC was developed by János Kornai to describe economic behaviour in socialist economies of the East bloc where loss-making firms were routinely rescued (Kornai et al. 2003). To this factor we also need to add the different incentives, both positive and negative, that are inherent in each sector. In early capitalism the rewards for success were great but the price of failure was perilous – an extreme version of the hard budget constraint. With the advent of limited liability and the progress of legislation the penalty for failure became softer but the rewards for success increased (Kornai 2009). Conversely the public sector manager faced steady if unspectacular rewards but over time the security of the position was increased and frequently carried a pension for life. Such a manager could, as Kipling said, meet triumph and disaster and treat the two as the same.
Much public sector reform of the last 20 years was driven by the philosophy of New Public Management (NPM) which sought to improve the power of incentives for public servants relative to their private sector counterparts on the positive side (Rainey and Bozeman 2000). In Ireland this has been reflected by large increases in the financial rewards of higher civil servants and equivalent positions across the public service. But on the negative side public servants world-wide have greater job security. This level of security may mean that not only will public organizations be supported through financial failure but the managers cannot and will not suffer any effects from such failure. The negative impact of failure for managers in the private sector may be that they will lose their jobs. Williamson (2000) argues that lower-powered incentives, more rules and regulations, and greater job security have been deliberately crafted into the public sector to make it more suitable to conduct transactions which are not capable of being carried out in the private sector. In reforming the state sector to mimic norms in private business the higher salaries paid to public sector managers whilst maintaining their job security creates disequilibrium in Williamson’s description. Indeed, financial constraints in the private sector, due to the economic crisis, have impacted negatively on private sector salaries while job security is in greater jeopardy than ever.

In the case of public industries which have been either privatized or substantially deregulated we can make the ‘before and after’ comparison of performance. In examining the liberalization of road building management in Nordic countries Groenewegen and De Jong (2008) found that initially with the involvement of the private sector there was substantial cost savings with no diminution of quality but over a period the transaction costs increased and after five years the overall administrative costs were at the same level as they had been. Not only that, but price competition had resulted in margins that made the road maintenance business so unattractive that the private firms were no longer interested in tendering for it. Despite a market failure the roads cannot be allowed to deteriorate and so government was forced back into the market.

In health care the picture is mixed as we have seen (Cooper et al. 2011, Propper et al. 2004). Duggan (2000) comparing for-profit, not-for-profit and government owned hospitals in the United States found the critical difference between different types of hospitals ownership is caused by the soft budget constraint of government-owned
institutions. It is difficult then to arrive at an impartial judgement as to whether service is better in the public or the private sector. In examining cataract operations we are minimizing some of the factors which may interfere with examining this question as the procedure has become simplified and standardized over the years. The next section describes the procedure.

6.2 Organization of the practice

6.2.1 Cataract Extraction: The Procedure
In order to understand how this procedure is delivered to the patient through the surgeon we now give a simple outline of the procedure and how it works. The lens of the human eye is normally transparent. With age cataracts can develop on the lens which affects the person’s ability to see. A cataract is a clouding of the lens making it difficult for light to get through. A cataract is not a disease and develops with age in the same way as grey hair does. Most people over the age of sixty will have some level of cataracts in their eyes but in many cases it has little impact on their ability to go about their daily business. In the cataract extraction operation the lens with the cataracts is removed from the eye and is replaced by an artificial intraocular lens. In most cases this is a short day procedure which is performed without a general anaesthetic. Modern techniques known as ‘manual small incision cataract surgery’ (MSICS) allow for a minimal incision into the eye and the existing lens is broken up using ultrasound and is sucked out through the incision. This technique is called phacoemulsification. Once the new lens is in place the incision is closed and the patient is free to go home. Due to the low level of invasiveness and the routine administering of antibiotic directly to the eye at the end of surgery the risk of infection is now much lower than it might have been in the past (Barry et al. 2006, Spalton 2009). Ever-improving technologies in the manufacture and the deployment of the artificial lens will make it possible to carry out this operation with even smaller incisions. In the past a cataract extraction operation was a major piece of surgery which, between preparation and execution, could last for several hours. The level of incision required and the need for sutures raised the risk of infection. In the modern operation all of these risks are greatly reduced. The question for the examining consultant may be whether or not to operate at all. The level of disability
and the functional benefit to the patient will vary from person to person and is an issue which could be a cause for debate within the profession. One surgeon put it this way:

‘…..generally in the public system .......... the criteria we use would be if you have six over twelve. In other words if a person doesn’t have good enough sight to drive a car or good enough sight to read then these people have what we would say is a functional deficit. Now you could operate on them with better vision than that and you’ll still improve them but there’s the risk then that the benefit would be much less. So in the private sector patients can be operated on where the actual functional benefit is much less so the benefit is to the doctor then’ (Surgeon SO6).

Another surgeon suggested that the decision to operate depended greatly on the patient’s needs and that the initial consultation is crucial to decide whether the surgery is indicated or not:

‘If a patient is not able to do their everyday tasks and enjoy life with the level of vision that they have and it’s due to cataracts that they have reduced vision then cataract extraction is indicated. So you may have an accountant who has got six over nine vision and he’s very unhappy and therefore surgery is indicated on the other hand six over nine vision to another person who doesn’t need such acute vision will be quite happy with six over nine even though there might be a little bit of a cloud there.’ (Surgeon SO7).

6.2.2 The Profession
The branch of medicine that deals with the study and treatment of disorders and diseases of the eye is referred to as ophthalmology. In Ireland the profession of this specialty is represented by the Irish College of Ophthalmologists. They describe an ophthalmologist as: ‘a registered medical practitioner who has completed a minimum of four years of specialised medical and refractive training and experience in eye care’ (Irish College of Ophthalmologists 2011). Ophthalmologists are divided into ophthalmic physicians and ophthalmic surgeons. An ophthalmic surgeon is: ‘a registered medical practitioner who has completed a minimum of seven years competency based specialised training in ophthalmic surgery’. The surgeons are the ones who perform cataract surgery. In general in Ireland patients are referred to consultant specialists by general practitioners (GPs). In the case of ophthalmic surgeons much of their work comes by reference from optometrists or opticians but some work comes from GPs. Occasionally they will get a self-referral. That is a
person who believes that they have a problem with their vision and makes a direct appointment for a consultation with the surgeon. Diagnosis is often made by an optician, a GP or a medical ophthalmologist working in the community. In most cases the surgeon will do a full assessment of the situation with the patient before proceeding to operate. In some cases where the surgeon has a close working relationship with the medical ophthalmologist no additional assessment is necessary and an operation can be scheduled. The treatment is often decided in discussion with the patient and if they are elderly also with their relatives. All patients are given the complete information they will need including a description of the procedure and the possible risks and benefits that can arise. In a pre-op assessment they get their biometry done which is an analysis of their corrective requirement using mathematical and statistical methods.

Ophthalmic surgeons in Ireland, like other consultants, work in a variety of public and private arrangements. Most surgeons who work in the public health system also have private practice. Operations in the private sector may be carried out in the public hospital or in a private clinic. As the vast majority of cataract extractions are elective and carried out as day cases under local anaesthetic most public patients are operated on in the public hospital and private patients are operated on in both public and private facilities. Because of the sophisticated and standardized nature of how this procedure is now carried out there is very little leeway for variations in the way the surgeon approaches the operation and therefore no opportunity for any potentially economically driven decisions. For example the standard lenses used in a cataract operation currently cost between €80 and €140. So if a surgeon was particularly disposed to one manufacturer’s product over others, for whatever reason, it would not have any great impact on the overall cost of the procedure. There are newer multifocal and other hi-tech lenses available now that are considerably more expensive than the standard ones costing up to €1,000 per lens. These are not covered by standard health insurance or in the public sector and so if a patient requests these they must be paid for by the patient. Outside of these considerations there is no difference between the procedure for a public patient or a private one:

‘…..when we take a lens out which has a cataract we replace it with another lens and that lens power is worked out mathematically so we don’t have that much room to manoeuvre’ (Surgeon SO1)
6.2.3 Interaction with colleagues

The question being asked is: do ownership differences have an effect on the delivery of professional services in health care? Professional norms among medical practitioners should serve to moderate any overt differences influenced by economic pressures (Andersen and Jakobsen 2010). Norms within any group are dictated by what becomes an acceptable way to function in that group and these norms also serve to regulate and control behaviour. When it comes to the higher professions such as medicine there are a number of authorities which will monitor and control the behaviour of its members. The Irish College of Ophthalmologists in common with most professional medical bodies has, for many years, had a scheme of continuous professional development. However, doctors are now legally obliged to maintain their professional competence and must enrol in professional competence schemes which are usually operated by the professional bodies. The Irish College of Ophthalmologists is the approved body to administer the professional competence scheme for ophthalmologists in line with the requirements of the Medical Practitioners Act. Each doctor has to retain 50 continuous medical education points per year to retain registration as a doctor with the medical council. These points are gained under a variety of headings including: Patient Safety and Quality of Patient Care; Relating to Patients; Communication and Interpersonal Skills; Collaboration and Teamwork; Management; Scholarship; Professionalism and Clinical Skills. So doctors function to professional norms and each sub-group of specialists, being a smaller group, is more likely to operate in a homogeneous way:

‘The Irish College of Ophthalmology in Ireland is a very tight-knit community, you see there’s only 60 – 70 of us and we have a lot of juniors and then we have these community ophthalmologists who are medical ophthalmologists who don’t do surgery. So I’d say that it’s a very intimate group’ (Surgeon SO1)

Surgeons’ ability to liaise with colleagues on an on-going basis depends on the circumstances of their practice. Some are practicing in a number of locations, both public and private and have daily if not hourly interaction with colleagues in both a professional and a personal way:
‘...we have educational meetings in the hospital on a regular basis to which everybody goes so we would meet professionally from an educational point of view. Colleagues discuss patient care and management and I suppose you’d meet socially as well from time to time’ (Surgeon SO5).

Some surgeons may work alone and may not have the day-to-day interaction but will nevertheless be in contact with colleagues:

‘Even though you can be working in isolation, which I am, but with the wonders of emails and mobile phones and things, for example, I had a colleague ring me recently from his theatre having had a particular problem, to seek my opinion on it there and then so this is the beauty of it so you may be physically isolated but you are not isolated when it comes to digital methods of communication’ (Surgeon SO4).

Although there are surgeons who work exclusively in the private sector and some who work predominately in the public sector there is not any concept of a ‘public doctor’ and ‘private doctor’. They are a homogenous group who have a similar educational background and are likely to have a similar social background. Of the surgeons interviewed there was a wide divergence in expressed ideological viewpoint however there was no disagreement generally on the ability of surgeons to do the best for their patients whether in the public or private sectors and whether they were getting a specific fee or a general salary. Therefore any directives which hospital management may wish to pursue, either in the public or private sectors will have to conform to the professional standards which have been sanctioned by the profession. We can conclude that any differences which occur or are perceived to occur between the two sectors are as a result of non-clinical factors outside of the control of the surgical professionals.

6.3 Remuneration for surgeons

Remuneration in any walk of life is likely to be an issue which can motivate people to work better or more efficiently. Badly designed remuneration incentive may have the effect of giving rise to behaviour which turns out to be the reverse of what was
intended. Therefore a short examination of the position in relation to surgeons in the Irish health system is necessary.

6.3.1 The Public Sector
Payment for consultant surgeons in the speciality of ophthalmology is similar to most of the major specialities. Work carried out in the public sector is paid for by way of a salary from the HSE. Consultant’s salaries have been a matter of controversy for many years. Irish hospital consultants are entitled to carry out private practice in the public hospital up to a limit of 20 per cent or 30 per cent of their total work depending on the type of contract they have. In the past it was perceived that some consultants were doing an excessive amount of lucrative private work to the detriment of their public duties but the extent of this was difficult to measure. A common contract of employment for consultants working in public and voluntary hospitals was recommended as far back as 1968 but the first one did not come into being until 1981. Before this contract, consultants in the public hospitals were salaried employees with limited rights to private practice and those who worked in the voluntary hospitals did mostly private work. The 1981 contract allowed for payment of a salary to both categories of consultant and allowed for consultants in public hospitals to take on private work like their colleagues in the voluntary hospitals and gave the consultants working in the voluntary hospitals the comfort of pensionable employment and the maintenance of their right to continue to do all the private work they had been doing (C & AG 2007). This contract was re-negotiated in 1991 and 1997 without substantial change. The 1997 contract stood for eleven years while torturous negotiations went on between the HSE on the one hand and the Irish Hospital Consultant’s Association (IHCA) and the Irish Medical Organisation (IMO) on the other. One of the difficulties faced by hospital management was in getting consultants to complete a schedule of commitments so as to make effective planning arrangements. In many cases the consultants operated in whatever way suited them and so it was difficult for management to estimate whether or not they were keeping to their agreed proportion of public to private work. In addition the 1997 contract specified that the consultants were to work 33 hours of scheduled activities and a further 6 hours of unscheduled activities being paid for a full 39 hours. The consultant’s representatives argued that unscheduled activities, such as teaching, research, administration or attending meetings, were to be carried out within the 33
hours. This difference in interpretation was not resolved until the new contract was finally concluded and agreed in 2008. The new contract gave the consultants a pay increase for agreeing to reduce their private practice and have greater work time flexibility. It also provided for greater ability to monitor consultant’s activities to ensure that they comply with the public/private proportion regulations. There is also the provision of a public-only contract where the consultant will work exclusively for the public system. The new contracts will apply to new recruits whereas existing consultants can continue to work under their old contracts. The aim is to increase the number of consultants in the HSE hospitals and reduce the proportion of Non-Consultant Hospital Doctors in the system. Most of the pay increases have been wiped out in the meantime by pay cuts required by the financial crisis.

6.3.2 The Private Sector
Payment in the private sector is exclusively by way of ‘fee per item’. Each type of surgical procedure has a set menu price laid down by the VHI and that is the guide for all payers in the private sector. Virtually all operations carried out in the private sector now are paid for by insurance companies. Up to July 2011 patients referred by the NTPF were a significant source of business for the private sector. Prices negotiated by the NTPF were similar to the VHI guide price. There are some cases where a patient pays ‘out of pocket’ for a cataract operation but it must be suspected that in some of these instances it is a public patient who wishes to skip the queue possibly with the financial assistance of family members. One private consultant surgeon put it like this:

‘If a patient who has no health insurance ends up in my clinic with a cataract I am assuming that they will have made an informed choice in terms of whether they can afford it or not’ (Surgeon SO4).

Private patients who have medical insurance have not been subject to the full economic cost of their treatment. The position and rationale for setting up the VHI was outlined in section 5.3.2 of the previous chapter.

The system used for reimbursing public hospitals for private treatment was a daily charge calculated on the average cost per bed-day on three different categories of
hospital using Casemix data. This is called the ‘per diem’ system. While it has been easy to administer it has the disadvantage of creating some perverse incentives and the charge does not necessarily relate to the actual resources consumed. The more complex and expensive cases would be much cheaper in a public hospital charging the per diem rate than having the same treatment in a private hospital. Further the ‘Value for Money and Policy Review of the Economic Cost and Charges Associated with Private and Semi-Private Treatment Services in Public Hospitals’ found that hospitals were waiting on average 5.7 months for payment from the insurance companies and in excess of €170 million was outstanding at the time of the report (DOH 2010). The system was still being processed on a paper based administration. The installation of an up-to-date IT system would improve collection for the provider and reduce transaction costs for the payer. The consultant is paid separately and most consultants stick with the VHI schedule of fees even though there have been reductions in the recent past due to the recession:

‘…it’s all fee-per-item and it would be controlled by the insurance companies and we’re entitled to charge what we wish but I’d prefer that the patient is fully covered. I’d prefer to negotiate through the IHCA or whatever to have a package so that the patient is happy. Previous to when I first started there was extra billing and that made things very difficult and a bit messy and from a patient’s point of view it wasn’t good’ (Surgeon SO7).

Remuneration for public jobs in common with many countries is by way of a salary. The salary gets paid whatever the level of activity is. Depending on the disposition of the individual surgeon this could act as an incentive not to do anything above the minimum. In the private sector all activity carries a payment and therefore there is a direct relationship between productivity and pay. A highly motivated person may carry out a great number of operations but the fear would be that some unnecessary work might be carried out. Activity in a relatively straight-forward operation like cataracts gives rise to greater earnings for the practitioners whereas the salaried doctor has little incentive to do extra work and may well be discouraged from doing so by cost-cutting managers as less activity means less budget used.
6.4 Methodology and data

6.4.1 Interviews
The methodology for this study follows closely on that used in Denmark by Andersen and Jakobsen (2010) and which we used in the study of the effects of ownership in the provision of hip replacements (see Chapter 5). Much of the statistical data available for the Danish study was available in Ireland for the public sector but not for the private sector. Most of the data came from direct semi-structured interviews with surgeons and hospital CEOs both public and private. In answering the question as to whether ownership affects the provision of professional services such as hip replacements or cataract extractions we found that the statistical information was of limited use in any case. An example is the question of re-admissions within 30 days due to a complication with the operation. If the statistics diverged greatly between the public and the private sectors we could suggest that a low figure was a measure of quality. A number of the private hospitals who were asked for these figures said that they would not know what the figures were but the surgeons would have those records. For this study we asked the surgeons directly for the re-admission rate. As we have seen already, in modern cataract operations it is a very small figure and is equivalent in both sectors and so has little bearing as a measure of quality.

The criteria used to analyse our research question are more restricted in the case of cataracts than in the case of hip replacements because the simplicity of what was once a very complicated operation to what is now, in many cases a procedure not any more complex than dental work. Therefore measures of quality, such as length of stay are not relevant because almost all patients are treated as day cases with some operations taking no more than twenty minutes. What we are left with by way of evaluation is how patients are selected, the amount of time they are waiting for their operation and the potential impact of management input to clinical decisions.

6.4.2 Data Collection
According to the Medical Council’s latest General Register of Medical Practitioners there are 73 registered ophthalmic surgeons in the Republic of Ireland (Medical Council 2011). We cannot be sure how many of these are in active practice as the Medical Council has several registered doctors who are aged in their 80s and 90s and
can be assumed to be retired from active practice. Discussion with the surgeons suggested that there are between 60 and 70. We have conducted semi-structured interviews with seven surgeons using the same questions which were posed to the orthopaedic surgeons. These seven interviews added details of behavioural and performance issues specific to ophthalmologists but are taken together with the previous nine surgeon interviews making a total of sixteen.

Using the website of the Irish College of Ophthalmologists as a starting point we went through the list of eye doctors excluding those names with the prefix ‘Dr’ as they would be ophthalmic physicians. Those listed as ‘Mr’ or ‘Ms’ were examined and only those who listed ‘Cataract Surgery’ among their specialties were considered. Using information from the website of the Irish College of Ophthalmologists 23 surgeons were listed as being specialist in cataract surgery. Others specialized in other types of eye surgery such as paediatric ophthalmology, retina surgery or did not specify a sub-specialty. We made contact by email with 21 surgeons. In many cases the email addresses were included on the website but we also telephoned the secretary in advance before sending. Of the seven, three worked in both public and private practice, three worked in private only and one did 90 per cent public work with the remainder in private. One of those in exclusively private work has retired from doing public work but had worked in both up to recently. All participants were promised anonymity and although quotations used within the text are exact words spoken some materials could not be used due to the fact that it would tend to identify the individual or an institution. This is particularly true in the case of Irish ophthalmic surgeons as they are a small cohort of people.

There is an element of self-selection in the interviews in that those who immediately volunteered to participate are likely to be more open and at ease with questions whereas it cannot be known if those who did not reply were simply too busy or opted out for other reasons. However after the first two interviews we set about specific targets to ensure that we had a balance of public and private. Of the doctors we telephoned a second time we found that nobody had any resistance to participation the only impediment was that of time. All of those contacted expressed a wish to be of help to the research and were open and candid with their answers. Although the number interviewed (n = 7) is limited it represents a sizable proportion of the target population: 10 per cent of ophthalmic surgeons as a whole and an even greater
proportion of those who are actually carrying out cataract operations in Ireland
today. Also by the time we had conducted the seventh interview we had reached
saturation point in some respects and the answers given to many of the questions
were similar to what we had already heard in the earlier ones and much of the
general attitudes articulated were similar to those we noted from the orthopaedic
surgeons. Data was analysed after each interview and some answers gave rise to
supplementary questions being asked of subsequent interviewees to verify the
answer. Certain areas of the questioning, such as the pricing of implants, had factual,
verifiable answers which did not vary between participants. Others, such as those on
motivation or attitudes were surprisingly consistent among the interviewees.
Saturation point is thought to have been reached when no further information
relevant to the study will emerge by conducting more interviews. Mason (2010)
analysing sample size and saturation finds a number of authors who conclude that
saturation point can be reached at relatively low levels (Griffin and Hauser 1993,

As with our previous study we subjected the answers to source evaluation and in
analysing texts we concluded that the material used was credible and the answers
plausible. The people who were interviewed are all highly trained, skilled
professionals who are all part of a professional organization. We can expect that in
any interview there will be a tendency for participants to give socially desirable
answers to certain questions. People will also be tempted to give evasive answers to
questions which seem to question the integrity of the profession particularly if they
believe that some colleagues may be letting the profession down. Defence is to be
expected (Bewley 2002, Rainey and Bozeman 2000). The questions were designed
to find a pattern to the behaviour and organization of the profession without the need
to ask direct questions which may have produced an answer which could not be
believed. In many cases after some routine ‘warm-up’ questions interviewees could
be become quite animated about a certain aspect of the profession such as frustration
with the public sector or conversely disappointment with colleagues in the private
sector. At no time did we feel that participants were being deliberately dishonest.
Where answers were not consistent with the general or something new emerged we
questioned these more closely to gain greater verification that what was being said
had credibility.
Such is the standardization and relative simplicity of the modern cataract extraction procedure that even with the expression of diverse ideological positions there was unanimous agreement on organizational behaviour and technical performance within the profession. As a result of our analysis of the entire surgeon interviews we are satisfied that the subset of interviews specific to the examination of cataract surgery is sufficient to be generalized the population of surgeons who undertake such operations, who, as we have seen, is not very large.

There is also some literature to strengthen our argument on sample size. Guest et al (2006) examined the question of saturation in interviewing women in West Africa. They conducted 60 interviews but found that a lot of the data was present after six interviews and most of it was there after twelve:

‘After analysing all sixty interviews, a total of thirty-six codes were applied with high frequency to the transcripts. Of these, thirty-four (94%) had already been identified within the first six interviews, and thirty-five (97%) were identified after twelve. In terms of the range of commonly expressed themes, therefore, very little appears to have been missed in the early stages of the analysis’ (Guest et al. 2006, p.73).

Romney et al (1986) found that small samples are sufficient in providing full and precise information within a particular cultural setting where the interviewees are experts about the subject of inquiry. The size of the sample can depend on the ‘cultural competence’ of the informants (Romney et al. 1986, p. 326). Once you are dealing with a homogenous group, in this case ophthalmic surgeons, with a high level of competence or knowledge in the discipline in which the inquiry is being made, variation in the answers may not be great and saturation point may be reached after a few interviews. In viewing answers to technical questions regarding the organization of the profession and norms of behaviour we can assume that if seven surgeons, interviewed separately, have given the same answer to a particular question that this answer can be generalized to the profession. The interviews were recorded, transcribed and coded into the software ‘NVivo’ using a set of nodes to categorize the different aspects of the interviews (see Appendix F).
6.5 Findings and Analysis

6.5.1 Surgeon motivation

A list of priorities was put to the surgeons about their motivation for doing the work that they do ranging from patient care to pay (see Table 6.1). They were asked to identify what their priority was, not necessarily to rank all the options. All replied that care of their patients was their number one priority and that the level of care given would not be in any way affected by whether the patient was a public or a private one. Most professional people do not want to suggest that money comes into their motivation at all but most will admit that they must be paid a correct rate for the job:

‘.....most people are in medicine because they want to give a patient service and that really rules the initial thinking so it’s the service to patients that is the primary motivation. I mean you obviously have to be paid fit to live and support your own endeavours but the primary motivation really is to offer a patient service (Surgeon SO5).

Table 6.1: Questions posed to ophthalmic surgeons regarding their motivation

<table>
<thead>
<tr>
<th>Motivation for work in the private sector: Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>To help patients</td>
</tr>
<tr>
<td>To give a good service</td>
</tr>
<tr>
<td>To provide consumer satisfaction</td>
</tr>
<tr>
<td>The quality of medical/surgical practice</td>
</tr>
<tr>
<td>Recognition of colleagues</td>
</tr>
<tr>
<td>Interesting tasks</td>
</tr>
<tr>
<td>Good levels of pay</td>
</tr>
</tbody>
</table>

Source: (Andersen and Jakobsen 2010)

In the private sector all work is paid for as ‘fee per item’ and therefore there could be a motivation for wishing to do more operations even if the procedure was not strictly necessary. On the other hand pay in the public sector is in the form of a salary and it could be suggested that the reverse motivation may exist in that the salary will be paid no matter how little work is done and so some necessary work could be avoided by a de-motivated doctor. These potentially different incentives would affect two different groups of patients in different ways. In practice most ophthalmic surgeons are well remunerated overall and therefore do not need to think of the economic considerations of any individual case. It takes many years of study to become a
practicing ophthalmic surgeon and many of the younger ones have qualifications above what is strictly necessary. Many are involved in teaching and research as well as doing voluntary and pro bono work.

Most surgeons found the public sector to be frustrating to a greater or lesser extent. Although the doctors are willing and able to process all the work that comes to the public hospital it was suggested that hospital management may be happy with less activity because it means using up less of the budget:

‘In a way there’s nearly an incentive not to work because by not working things are cheaper. The less patients you see the more money they save……the public system it is really like that and I suspect that they don’t care really about individuals and it’s just a culture that is there at the moment that balancing books is the be-all and end-all…’. (Surgeon SO6).

The culture of the public sector was not seen as being conducive to innovation. Managers in the public service were not prepared to facilitate suggestions from the profession which could improve the service:

‘….through the years you come up with ideas to try and improve the service and initially the administration are receptive to new ideas but the system usually beats you because you go round and round in circles having meetings and projects go nowhere. That would be my experience’ (Surgeon SO7).

In spite of this, surgeons stated that their motivation to help patients was the same in the public sector as it was in the private. There was less evidence of any level of frustration with the private clinics.

6.5.2 Selection of patients in both sectors
Patient selection or de-selection on economic grounds would provide evidence that a sector is cream-skimming, that is, selecting patients with characteristics which will not give rise to inordinate levels of expense which are above average. As patient selection is one of our evaluation metrics it is important to examine the factors at play in the public and private sectors. It is important to note here that we have a variety of ‘selections’ or choices for some and a more narrow choice for others. These choices will begin with a patient selecting their GP. This will lead to a consultation with a surgeon who may be recommended by the GP or be a patient’s
preference. If an operation is indicated the patient may have a limited input to the choice of hospital or more likely the surgeon will take that decision. The hospital manager may have some say in the admission of the patient to the hospital and when this is agreed the surgeon will determine the type of operation and the prosthesis to be used. The initial choice of GP is open to everyone whether in the public or the private sector.

Many Irish consultants work in both the private sector and the public sector. As with other disciplines, such as orthopaedics, these doctors have the choice as to whether to operate in the private clinic or in the public hospital when dealing with their private patients that is patients who have private health insurance. The only public patients who were treated in the private clinics were those who were referred through the NTPF. Where the choice was available there appears to have been no economic incentives to that choice and so most private patients are treated in the private clinic and most of the public patients are treated in the public hospital (verified by a number of surgeons interviewed). In examining the case of hip replacements we found that the primary reason in opting for one location over another was the level of security of better back-up facilities in case of emergencies and the skill sets available in the case of more complicated cases. In cataract operations the procedure is less invasive and patients are not put under general anaesthetic and so this choice rarely has to be made:

‘There may be patients who are difficult from a medical perspective so their management in and out of a private hospital might be quite difficult and in those circumstances you might do them in the public hospital because of that. But really they would be very few and far between’ (Surgeon SO5).

‘....for cataract surgery the most basic hospitals would still be able to manage them it’s a matter of what type of protocol you have’ (Surgeon SO7).

Most surgeons suggested that there was virtually no patient who could not be treated in a private hospital. Those working in the private sector were particularly emphatic about it but one surgeon suggested that if there were particular complications which warranted an operation to take place in a public hospital it was the skill set of the personnel that was the deciding issue:
‘The private patients who I try to do in the public hospital are technically demanding, they’re more difficult, they’re going to be surgically more difficult, the pre-op care is more critical, the post-op care is more critical and in a public hospital I have generally got a fairly senior doctor operating with me so in other words it is the complexity which determines whether somebody is done privately or publically....a very difficult complicated cataract operation I find better in public hospitals because the skill set of the nurses is better and the skill set of the doctors is better’ (Surgeon SO1)

A similar sentiment was expressed by some orthopaedic surgeons but this may be simply an individual preference due to location and personal relationships with trusted colleagues when dealing with more complex cases. Most surgeons did their early training in public hospitals and may find that they have greater comfort in operating in this environment where the procedure is particularly challenging. But there are circumstances where private facilities would face difficulty with some classes of patient but it is organizational rather than economic:

‘Private hospitals in general are very good for the vanilla stuff but they don’t want patients who are going to end up having to go to ICU and ambulance transfers and all the rest of it then it doesn’t either suit the patient or the hospitals’ (Surgeon SO5).

An alternative view is expressed by a surgeon who works exclusively in the private sector:

‘I think that the patient gets a better service in the private and the only difference I would say is that in the public sector you may get a consultant doing a procedure or you may get a trainee. Whereas in the private sector you know who’s going to be operating on your eye’ (Surgeon SO3).

It is noteworthy that surgeons who have the freedom to work in either sector opt for the public hospital for the more complex cases or for cases where they anticipate there could be complications. The argument for the private sector in these situations is being made by a surgeon who works exclusively in the private sector and therefore does not have that choice.

### 6.5.3 Waiting Times

The most noticeable difference between the private medical sector and the public medical sector in Ireland is the waiting times difference. This is one of the few
performance indicators which can be used as a measure of performance between the two sectors together with patient selection.

Generally people in the public sector wait a lot longer for their medical and surgical treatment. In the case of cataracts the official mean waiting time is approximately 3 months (see Table 6.2). Many of the surgeons asked suggested that the waiting time for public patients was closer to 12 months:

‘...in the public it can be up to 12 months, in the private you could get done in a week’ (Surgeon SO2)

Other surgeons suggested that waiting times even for private patients could be up to 4 months which suggests that some practices have built up long waiting lists in both sectors while others have the time and capacity to do more work:

‘Do I think we need more? That’s an interesting question the answer is no I don’t think so I think the ones that are there aren’t working to capacity if you know what I mean’ (Surgeon SO3).

As can be seen from the above quote there are surgeons who are well established and have waiting lists in both public and private. Then there are others (younger) who are not yet able to get into the public system and who may be under-employed in private practice until they develop a sufficient reputation.

Table 6.2: Waiting Times in Months for Cataract Extraction in Irish Public Hospitals November 2010

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Months Waiting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cork University Hospital</td>
<td>2</td>
</tr>
<tr>
<td>Letterkenny General Hospital</td>
<td>3</td>
</tr>
<tr>
<td>Mater Hospital Dublin</td>
<td>4</td>
</tr>
<tr>
<td>Mid-West Regional Hospital Limerick</td>
<td>3</td>
</tr>
<tr>
<td>Royal Victorian Eye &amp; Ear</td>
<td>3</td>
</tr>
<tr>
<td>Sligo General Hospital</td>
<td>2</td>
</tr>
<tr>
<td>St. Vincent’s University Hospital</td>
<td>2</td>
</tr>
<tr>
<td>University College Hospital Galway</td>
<td>5</td>
</tr>
<tr>
<td>Waterford Regional Hospital</td>
<td>4</td>
</tr>
<tr>
<td>National Median Wait Time for Adult Procedures</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: (National Patient Treatment Register 2010)
6.5.4 Standards of treatment

It would be hoped that standards of treatment would be the same no matter what route the patient took to get into the system. Indeed all of the surgeons interviewed believed that this was the case and because of the nature of the procedure there was little room for varying standards in any case even if they were minded to do so. This is a typical comment:

‘….it’s the same no matter how much money you have you get the same operation’ (Surgeon SO6).

The equipment used to carry out the procedure is very expensive and if maximum efficiency was the principal goal of a clinic the equipment would be used to the maximum time, constrained only by the number of available surgical personnel. For a private hospital once the equipment is put in place and is financed it will continue to deliver a standard fee of known quantity from the insurance company every time an operation is carried out up to the end of its useful life. It is in the private hospital’s interest to ensure that as many operations as possible are put through the system. In the public sector the number of elective operations is constrained by the impact of other activities in the hospital including restrictive practices which may have grown up in long established institutions. These may impede the optimum use of their resources.

In ophthalmology if a greater variety of expensive, hi-tech implants become more commonly used and are demanded by the public then there could be an incentive for greater management involvement. One surgeon puts the position thus:

‘I think in modern day cataract surgery there’s no decision there in terms of implants. Every patient will be clinically assessed. Now after that it is really surgical preference no more than any product on the supermarket shelves or whatever there are quite a range of different lens implants from different companies out there’ (Surgeon SO4).

Some surgeons believe that public service delivery of this procedure is likely to become more restrictive rather than less because of the example of experience in the British NHS:

‘…in the public service we have a very large range of discretion as to what we can use and I know if you are in the NHS you’ll be told: ‘this is the bulk purchase lens and this is what you’ll use – full stop’ (Surgeon SO5).
However even the relatively expansive lens implants at €1,000 – €1,200 will not
have the same impact on the overall price of the operation when compared to the hip
replacement where the cost of the prostheses can be much more significant.

6.5.5 Clinical results
Modern cataract surgery is one of the most common elective procedures undertaken
in the western world and increasingly it is also the safest. Re-admission of a patient
due to complications with their operation is a measure of the quality of the clinical
results. All surgeons were asked: what was the percentage of patients who had to be
re-admitted within 30 days due to a problem with their operation? All answered that
it was a very rare occurrence in the modern era with the possible figure being less
than one per cent:

‘I’d say less than one per cent, it’s very small. I mean in the old days when
cataract surgery had large wounds and a lot of sutures and potential for
infection and wound breakages and leakage from the eye and you would have
had a significant amount of returns, maybe around three per cent but
certainly with the new technology and the new surgical approaches the
numbers coming back into hospital for corrective surgery is minute’
(Surgeon SO5).

This makes the procedure one of the most successful of all operations and therefore a
source of some pride and satisfaction to the surgeon who performed the surgery:

‘….cataract surgery is one of the most satisfying operations of all operations
in all specialities because you get such a good result quickly’ (Surgeon SO7)

Evidence-based guidelines for cataract surgery from the European Society of
Cataract and Refractive Surgeons (ESCRS) suggests that complications from
conditions requiring attention post-surgery are usually fractions of one per cent
(Lundström et al. 2012). Clinical results are dependent on quality outcomes. The
question of quality is somewhat subjective and may mean different things to
different people. All of the ophthalmic surgeons were asked to give their
understanding of the concept of quality in terms of patient satisfaction and clinical
quality. Quality outcomes in any surgical procedure can be used as a measure of how
different locations and practitioners have performed. The evidence from all surgeons
interviewed is that there is no difference of any kind between a cataract operation in the public sector with an operation in the private sector. With cataract extractions, in particular, measurement of the outcome can be exact and comparable with other data:

‘...it’s very easy if you are doing cataract surgery on somebody you expect a certain outcome and the outcome can be measured – it’s the patient’s vision after their surgery and if you don’t reach the expected outcome then obviously you would consider that you hadn’t provided the quality of service that you had offered and then you have to look at why that is the case. Did you offer too much? Was what you offered attainable in the first instance? Because if patients have other eye disease they may not have 20:20 vision after an operation so it’s all really down to do with proper examination of the patient before the surgery and only promising what you can actually deliver’ (Surgeon SO2).

A number of surgeons expressed the opinion that the ultimate measure of quality was the satisfaction of the patient but there are many factors which determine that quality outcome:

‘The most important thing in quality for me is the correct decision. In other words have you made the correct decision to operate? Then you have infrastructural quality which is where your physical, microscope your instruments are correct. Then you have HR quality where you have you know, are your nurses as good as they can be? And then you have the post-op quality and then you have the final patient satisfaction if you want to call it that. So I think it’s a kind of global term’ (Surgeon SO1).

Apart from getting patient satisfaction and assuring themselves that they and their team have done a good job there are also audits of quality:

‘.....from a technical point of view all the surgical work is audited and many of the surgeons are part of the European Cataract Assessment Scheme which is run by the European Cataract and Refractive Surgical Society. There is an audit base in Scotland where everybody can file into anonymously and get their own results back and see where you rank according to the European profile’ (Surgeon SO5).

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18 The European Society of Cataract and Refractive Surgeons (ESCRS) with eleven National Societies created a European registry for improving quality of cataract and refractive surgery. European Registry of Quality Outcomes for Cataract and Refractive Surgery (EUREQUO) has been co-financed by the European Union, under the Executive Agency for Health and Consumers (http://ec.europa.eu/eahc) and the ESCRs.
Most surgeons expressed the view that patient care was their number one priority and so it is the patient’s perception of an improvement in their quality of life that is most important. Most patients want an operation that is quick, pain-free and without excessive surgical risk (Spalton 2009). In addition patients benefit from being treated with courtesy and sensitivity. Increasing demands for productivity may have an adverse impact on this. Currently, we can conclude that the majority of cataract patients treated in Ireland get a quality service and that service does not vary between the public and the private sector.

6.5.6 Satisfaction with service and choice
The issue of patient satisfaction with the service of cataract extractions, from the patient’s point of view, cannot be ascertained directly from any data exclusive to that particular procedure. So the question was excluded from the study on cataract operations. We have in the previous chapter given an overall impression of the levels of satisfaction expressed by patients in the public sector and compared that to the available data for the private sector and a similar situation may apply to the cataract procedure, however there are differences. First the cataract extraction operation is, in the majority of cases, a day operation, more akin to dentistry and so patients do not get several days in a hospital with time to form a positive or negative view of the institution. Second, although the level of clinical improvement is directly measurable in an objective way, the patient’s own perception of the level of improvement may vary with expectation.

It may be concluded that satisfaction or lack of it, from the patient’s perspective is reliant on the perception of their treatment by the surgical staff and the outcome, which our surgeons assure us is almost always positive. Some international literature suggests that satisfaction with the cataract operation is linked with waiting times – those who wait longer are less satisfied (Conner-Spady et al. 2004). This would suggest that, in the Irish case, public patients would be less satisfied than those in the private. Others suggest that the more information supplied to the patient and meeting the surgeon are determinants of satisfaction (Wasfi et al. 2008). Most surgeons state that this is standard procedure:
‘they all come in for a per-operative assessment and there is a set protocol which is run by senior nursing staff so that really makes sure that they are physically fit for the operation, that they understand exactly what’s going to happen and they see the ward and they know what the protocol is prior to coming in for the surgery so there’s no big shocks really when they arrive and they get leaflets of pre and post-op care of the eye so I think they get a good information package and elderly people rather than reading leaflets they actually need a face to face arena in which they can address their fears and concerns about the surgery and what’s going to happen and everything and the personal visit to the day ward for their assessment is usually very valuable from that point of view’ (Surgeon SO5).

Market reforms of the health systems in both Britain and Sweden in the early 1990s provide us with a view as to how this innovation affected choice for the end user. Fotaki (1999) made a study of how these reforms impacted on choice and information regarding cataract operations. Increased choice is often put forward as one of the benefits of greater market oriented liberalization of a sector. It suggests that restrictive practices beneficial to sectional interests can be set aside. But this study found that there was less choice after the reforms and that many were not aware of the changes. The provision of full information allows a patient to make an informed choice. By its nature cataracts are associated with ageing and therefore the majority of patients will be elderly and the decision whether or not to have an operation may be allowed to rest with the patient and their family in consultation with the surgeon. Studies have shown that elderly people would prefer these decisions to be made by professionals (Fotaki 2007).

The final choice of whether to operate may be left up to the patient but that choice will be made in the light of the information and indicators given by the surgeon:

‘I let them completely make up their own mind as to whether they want to or they don’t want to. Sometimes they ask: ‘what do you think doc?’ and I just say: ‘it’s not my eyes it’s not my life you need to decide, all I’m telling you is: this is what can be done – these are the advantages to you and it’s up to yourself if you want to go ahead’. I encourage family members, if they come with them to the appointment, to come in because I think it’s important for them to have a second set of ears so that they can bounce ideas off someone to decide whether they go ahead or not’ (Surgeon SO3).

So choice, information and managing expectations all play a part in the ultimate perception of satisfaction of the patient.
6.5 Conclusion

In this chapter we have made a further examination of the possible effects that ownership of medical facilities may have on the provision of professional surgical procedures and in particular cataract operations. Cataract operations are one of the most common elective surgical operations carried out in Ireland today and examination of the procedure builds on the knowledge gained from our investigating of the subject using hip replacements. Cataract operations like hip replacements are carried out in both public and private clinics and are elective so that a direct comparison can be made between the two sectors for this particular procedure. There are many surgical procedures carried out at public hospitals which could not be successfully studied to make a comparison with the private sector.

In terms of criteria used there is little difference between public and private when it comes to cataract operations except the waiting times endured by the public patients. Cataracts extractions are an area where the private sector can outdo the public in terms of volume and cost efficiency but there is no reason why a re-organized public sector might not be able to increase efficiency.

Surgeons are motivated by the highest principles of wishing to give the greatest care for their patients. It would be easy to take a cynical and envious view of the profession because they are among the highest paid people in the country. However a high level of pay is a fact of life for this profession throughout the world and represents what Herzberg (1968) would call a ‘hygiene’ issue – that is a factor, the absence of which could cause professional dissatisfaction rather than a motivational factor.

Favourable comment regarding either the public sector or the private sector could be expected to break down along ideological lines but in our study we found that despite some trenchant ideology being expressed all surgeons agreed that the operation was identical to all patients. They also agreed that virtually all patients could be treated in either type of facility with rare exceptions. The big divide between the two sectors is the waiting times experienced by the public patients. It has been suggested that better use of surgeons’ time could resolve this issue without the need for increased surgeon numbers.
Management does not interfere in any way with the conduct of professionals in this sub-speciality. As we have seen previously much of the ethos of the profession ensures that norms are adhered to irrespective of management wishes. But in cataract surgery there is little scope for any gain on the part of management. The greatest criticism was reserved for management in the public sector who are under pressure to contain costs. Their position is the reverse of private sector management who wish to maximize revenue.

Ownership of facilities which carry out the procedure of cataract extraction has little bearing on the clinical outcome or quality of the service being offered. We have seen, previously that professional norms regulate the activities of the surgeons. The only thing to be concerned about in this area is the decision whether or not to operate in the first place and this is a professional choice which we entrust to the consultant. The scope for putting economic considerations ahead of clinical concerns is extremely limited in the case of the cataract operation. Virtually all private patients are treated in private hospitals or in private clinics held in public hospitals and all public patients are treated in the public clinic. The procedure is short, requires only a local anaesthetic and is mostly carried out as a day case. The implants and other consumables are relatively cheap and private clinics maximize their productivity by through-putting as many operations as they can. Professionalism neutralizes many of the ownership differences. The conclusions thus concur with the rejection of simplistic and axiomatic relationships between the type of ownership and performance (Willner and Parker 2002, Andersen and Jakobsen 2010).
Chapter 7: Conclusion

7.1 Introduction

The problem of funding public services to the extent modern society demands has been increasing since the end of the Second World War. The problem is even more acute in the case of public health services. It is, and will always be, difficult for politicians to make a case for savings and reduced funding for what may appear to be a matter of life and death. The early 1970s saw the end of a sustained period of economic growth in Western Europe and the United States and with it came the need for fresh economic thinking and ideas. There had been a growing dissatisfaction with government-run institutions from the great offices of state to state-owned enterprises in many countries and the advent of New Public Management, particularly in the United Kingdom emphasised the potential role of the private sector in the delivery of government services. The aim of this thesis has been to analyse the provision of health services in Ireland with a view to ascertaining the relative strengths and weaknesses of that provision being delivered by the state through the public system or through an incentivized private sector.

Ireland’s health service is supplied to the public through a mixed system of public and private delivery in common with most developed countries. The blurring of the line between the public and private sectors gives rise to what many commentators refer to disparagingly as the ‘two tier system of health care’ (Wren 2004, Burke 2009, McDaid et al. 2009, Nolan and Nolan 2004). This seemingly unfair situation suits some of the actors within the system. Should they choose, consultants are able to command very high earnings often by pushing the regulations to their limit and beyond, such as, the limits on private work in public hospitals. Over 50 per cent of the population held private health insurance in 2005, today this figure is down to 43 per cent which is still high by international standards (Millward Brown Lansdowne 2012). The private sector has been encouraged and supported by government for a number of years.

When comparing the public sector with the private in health services it is not a question of either one or the other. It is clear that the private sector handles some
issues in a more efficient and cost-effective way than the public. But the private sector needs profits and there are many areas in health where there is little likelihood of profit. Areas like mental health and neurology are strikingly different to procedures like hip replacements where a good outcome is the expected norm. The private sector is not as independent of the state as is sometimes alluded to, as businesses are subject to regulation. This is critical in health care. Regulation and taxation can be used as instruments to incentivize and shape the pursuit of private business. The public is also likely to be wary of private interests wishing to profit from something which may previously have been considered a merit entitlement.

Experiments with privatization, public-private partnerships and a variety of market-based reforms have been carried out in other countries with mixed results. Chapter 1 provided the context for mixed delivery of services. Countries such as the United Kingdom, Sweden, Australia and New Zealand were foremost trying different methods of delivery and if we can take one lesson away from all the doing and undoing of ‘reforms’ is that those countries which spend the greatest proportion of their GDP on their health services are the ones which have better services. France, Germany, Belgium and Switzerland which have varying systems of delivery, all spend between 10 and 11 per cent of GDP on health care (OECD 2012). In Britain, history has shown that problems with the NHS coincide with periods in which the percentage spending on health drops (Rivett 1998). This is not to conclude that simply throwing large sums of money at the problem will, of itself, resolve issues which have been problematic. Ireland is now spending 9.5 per cent of GDP on health which compares to 9.8 per cent for the United Kingdom. However when this spending is expressed in Gross National Income (GNI) which excludes profit exports not available for national consumption, the health spending figure is 11.4 per cent which ranks Ireland 6th out of 27 OECD countries (HSE 2011). Yet we have a long way to go before we can say that we have a first class health service.
7.2 Research Rationale, Research Questions and Methodological Approach Revisited

It is clear that the demand for health services throughout the world is set to increase due to ageing populations, greater survival and longevity, and increasing medical and surgical technologies. Many countries, particularly in Western Europe have experimented with using the resources of the private sector to enhance the ability of the state to meet the demand triggered by an ageing population, greater wealth and the technological advances being made in medical and surgical treatments. What is the right balance between public and private? The private sector may seem more efficient but there is always the suspicion that profits driven by efficiency are simply flowing into private hands when many believe that health care is a merit good – something the citizen is entitled to when it is needed. On the other hand a purely public institution is subjected to many different influences and different power groups pulling in different directions that its focus of operation may not be as precise and will undoubtedly be subject to criticism from all parts of the citizenry.

In order to make an attempt to analyse the differences between the public and the private provision of health services in Ireland it was necessary to examine the performance of different sub-sectors within the service where it was possible to make direct comparisons: nursing homes, hip replacements and cataract extractions. Before analysing these case studies we examined two cases where there was an attempt to infuse private sector involvement in areas previously the preserve of the public sector.

The research on nursing homes was facilitated by the creation of a brand new database and subjected statistical analysis. Some of our other cases did not have the convenience of readily available data. The data on hip replacements and cataract extractions needed to be gathered by the method of interviewing people who are at the centre of these procedures, both technically and from the point of being the chief decision maker. These were largely consultant surgeons. Such people are busy and in the normal course of events it is difficult to get to see them professionally. However, each one of the sixteen surgeons was given the same set of questions (see Appendix G) (Andersen and Jakobsen 2010). We interviewed a total of 33 people in the course of this research to build a picture of what could not be ascertained from publically
available data. The interviews yielded in excess of 150,000 words of text which formed a rich source of information with which to draw some conclusions. The motivation of highly paid professionals could be cynically attributed to greed and a need to earn more and undoubtedly there are some who fall into this category but we conclude that the majority do not. The differences between the public and the private delivery of surgical services are not economically driven but they are institutional and systemic.

In the case of the proposed co-located hospitals, little of the rich detail of the ‘behind the scenes’ battles ever emerged into the public domain. Some of this was due to legal embargo on parties who had signed the project agreement and there may have been some embarrassment on the part of those who took part in the process in the sense of how far they got things wrong. It seems clear that the ‘preferred bidders’ strongly believed that they could alter the project agreement after planning permission was granted to commence the construction phase but the alteration in the contract required to get their finances in place was specifically excluded by the terms of the Competitive Dialogue process. It appears that they were ill-advised or somehow misled.

The NTPF was presented as a ‘common sense’ private sector solution to an on-going problem of waiting lists in the health services. However, its operation provided far too many opportunities for actors within the service to game the system to their own benefit and showed little promise of altering the fundamental causes of the waiting list problem.

### 7.3 Core Findings and Contributions of the Research

This thesis investigates the current state of performance in different routes of service delivery in Ireland. In particular it examines attempts to alter the institutional arrangements in favor of the private sector.

Much of the initial flurry of excitement for privatization and private sector involvement in the delivery of health services waned after it failed to produce what it promised (Mays and Devlin 2005, French et al. 2001, Glasgow 2009, Magnussen et
This was particularly noticeable in Sweden and New Zealand where many market-based reforms were reversed after a short experiment. But the continuing attraction of PPPs and PFIs, with their promise of extra funds which do not show up on government balance sheets, is far too alluring for politicians to ignore. Indeed in Britain the pursuit of PFIs occasionally became an end in itself – finance looking for a home – rather than a solution to the provision of a piece of infrastructure (Monbiot 2007).

We examined why the proposals to put some public health service provision in the hands of the private sector failed in Chapter 3. In both the HCP and the NTPF the Three Layer Schema (Saleth and Dinar 2004) outlined in Chapter 2 points to all the factors which were in play to ensure that the proposals would ultimately fail. The battles for the retention or extension of power by different groups were central to the outcomes in both cases. The relative success of the SDU within the public sector shows the NTPF to have been what one doctor referred to as ‘a band aid’. Both of these proposals went against the best interests of those who had the ability to either not allow them to succeed, as in the case of the HCP, or bring to a close, as in the case of the NTPF. Closer analysis suggests that these initiatives were not in the best interests of the population at large in any case which leaves some hope that some of those who control public policy are also in tune with wider society.

When examining public verses private delivery in the case of nursing homes we had expected to find that there was a greater quality of care in the public sector and that this would be reflected by a greater adherence to proper procedure and regulations. This expectation was prompted by literature from other countries which suggested that this was the case. We set about compilation of the data by opening up each inspection report for every nursing home in the country. All homes had at least one inspection and some had as many as seven. From these reports we were able to gather all the relevant information to make the comparisons which we needed to answer our questions. The dataset we assembled on the performance of nursing homes was not merely a population sample but the entire population and the findings were striking. The evidence is that ownership is an issue in the provision of nursing home care with respect to cost, efficiency and quality of care. Private sector operators prove themselves far more flexible in their ability to address deficiencies and care levels do not seem to be compromised. The level of investment required to
bring the portfolio of public nursing homes up to a position where they can compete on an equal footing with the private ones is something which cannot be contemplated in the current economic climate. It is currently estimated that as many as 109 of the 131 state-run nursing homes will not meet HIQA standards by 2015 and to get them up to that standard may cost in excess of €700 million (Wall 2013).

It is clear that a well-regulated private sector in the nursing home industry is going to be the way forward. As we have seen in the United Kingdom and the United States the danger in private ownership is that corporate, multi-unit ownership models tend drive profits by cutting costs which impacts quality. This has particularly true in the case of private equity partnerships. In Ireland today private ownership is largely in the hands of individuals, couples or small partnerships where a single nursing home is the focus of the management’s attention. In this situation we can be reasonably confident that the enforcement of regulation will be more rigid than if control of homes was concentrated in large corporate hands.

In our first two cases the public sector won out in a tussle between the two sectors about co-located hospitals and the provision of surgical services by the private sector to publically sponsored patients. This also appears to be the better outcome. In the case of the nursing homes the public sector is in a position where its share of the industry will continue to decline in favor of the private sector. Again this appears to be the better outcome provided governance and regulation are kept firmly in place and are strengthened. The position of whether public or the private delivery may prove to the better outcome in the cases of hip replacements, cataract extractions and indeed other elective surgery is less clear. Ownership, of itself, is not an issue but some of the circumstances surrounding ownership can give rise to the potential for controversial issues to arise.

Those who are in favor of public provision of services may suspect that private operators are motivated purely by greed and that there is always an adverse relationship between profits and quality of care. They would also say that the private

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19 Each of up to five reports we examined for the 612 nursing homes contained a section entitled ‘Management Structure’ in which the nature of the ownership was outlined. Examples would be: ‘directors are a husband and wife team’ or ‘centre is operate by the Sisters of Nazareth and comprises six houses’
sector ‘cherry picks’ the less complicated and more profitable cases and if complications arise the patient is dumped back into the public system in any case.

Those favoring the private side would argue that they provide a faster more efficient service to a market which demands it and it also takes pressure off the public system. The fact that most surgeons work in both sectors and continue to exercise a great deal of autonomy goes a long way to preventing managers in either sector from gaming the system for their own or their institution’s financial benefit. Whilst this autonomy of the surgeon keeps this equilibrium we would have to say that on balance the more complicated work is carried out in the public hospitals. It is interesting to note that doctors who were asked about their choice of location for complicated cases mostly favored the public hospital citing the skillset of the surgical staff as much as the back-up facilities such as intensive care or cardio unit.

That is not to say that the private sector is inferior or that the public sector is always superior in terms of quality. The cataract operation is an example of a procedure which, at one time, was a very complicated operation prone to infection and subsequent re-admission and revision. Today it is a routine day-case operation and in most cases is completed within twenty minutes. Apart from some surgeons maintaining the mystique the procedure is no more complex than basic dentistry. So it is a perfect sub-discipline for the private sector. This and other elective surgery – a narrow menu of services – could be described as ‘cherry picking’ from the whole list of potential procedures which a large general hospitals might be asked to undertake. But, why not? Surgeons who had abandoned the public service due to the frustration of continuously having their surgery list cancelled or postponed in a general hospital due to other happenings at that hospital express their happiness at being able to plan and execute their surgery list without interference. Obviously emergency cases and cases which require long-term treatment are better taken care of in a hospital which is multi-disciplined and has the maximum facilities and this, in the majority of cases in Ireland today, would be in a public general hospital.

Arising from the findings we believe that this thesis makes a contribution to the knowledge in a number of respects:
7.3.1 Empirical contribution
This thesis offers new, empirical data on consultant surgeons, how they work, how they make decisions, their education and the incentives in the environment in which they operate. Irish consultant surgeons are highly paid and occupy a high social status within society. They are difficult to contact and have not previously been subjected to any questioning as regards their motivation and how they view their work in terms of their interaction with the private sector and the public sector. Our findings back up the functionalist sociology of professions theory of knowledge-based occupations which suggests that clinical procedure is controlled by professional norms and therefore we can expect no difference in these procedures in whichever sector they are being delivered.

Similar empirical data was produced on the background to and the motivation for the hospital co-location project were we had long and in-depth contact with the CEOs of the preferred bidders and under-bidders as well as the lawyer who wrote the controversial project agreement, among others, who were central to the project. This type of insight to motivation, attitudes and seeing at first hand the sometimes flawed arguments with which the principals engaged was more valuable than any set of numbers which could have been produced in its place. While the bid to create the co-located hospitals will be consigned to a footnote of history the anatomy of how the process unfolded (or failed to unfold) is a unique vestige into the workings of the public policy power makers of Irish society.

7.3.2 Conceptual contribution
In the search of a better understanding of the differences between ownership types we went back to the basics of what constitutes ownership in common law and how property rights developed historically. Property rights bestowed, on the owner or holder of a lease to property, certain rights to avail of the economic produce of that property. But ownership is not absolute or without limits. The level of autonomy which a property owner could exercise over that property has ebbed and flowed over time and this pattern was dependent on what regulation and governance was in place at any given time. The line between what constitutes outright ownership, leasehold or just economic control are not at all clear when examined closely. We noted in Chapter 2 the position of shareholders in a large company: Demsetz (1967, p.358) writes that: ‘shareholders are essentially lenders of equity capital and not owners’. 
These ‘owners’ of shares have ceded management decision rights to a group of professional managers who are the *de facto* ‘owners’ of the business.

If we look at the position of private ownership of facilities for the delivery of health services it is clear that the business owners are not able to exercise absolute control over their assets, rather they are dependent on regulation and governance which is decided by government. Where ownership types can currently impact the delivery of services is that incentives, such as pay, can be put in place more easily to achieve the desired result. But even this can be regulated by government through tax policy if not directly. Pay in the public service is far more complex and interdependent on many politically sensitive issues and so the rigidity of public bureaus limits their ability to be as flexible as they would need to be if we were to judge them on commercial terms. The concept of ownership needs to be considered with the concept of control.

### 7.3.3 Theoretical contribution

How we organize the delivery of care and how it is paid for will decide whether as a country we will deliver an efficient service for the level of expenditure that we incur. Regulation, inspection and enforcement are the keys to a good régime in the nursing home industry. Equally, regulation on the part of doctors’ organizations as well as statutory regulation has seen the maintenance of clinical autonomy on the part of doctors. Transaction costs economics (TCE) is central to any examination of the production of health services. Increased transaction costs will follow any move in the direction of a health service financed by private insurance. Unregulated health insurance markets can give rise to transaction costs as high as 45 per cent of the premium income (Hsiao 1995). It is not purely a matter of cost in the short-run, there is also the issue of risk. Lower cost in the short-run may store up problems for the future and therefore governments may choose a production mechanism which also minimizes risks associated with delivering services under alternative institutional arrangements (Brown and Potoski 2005). There are theoretical arguments linking transaction costs to government choices. Limited information and uncertainty can give rise to transaction costs particularly when contracting parties cannot fully predict all possible future scenarios, they cannot fully specify contracts. This is even more the case when investment assets are specific to a particular investment. The asset specificity issue was particularly pertinent to the hospital co-location case.
7.3.4 Methodological contribution

The health service of any country is a large and complex undertaking. The expression ‘health service’ is very sparse to describe the array of different individual tasks which are carried out on a daily basis. In order to examine public versus private provision of health services in Ireland we were confronted with a number of obstacles. Much of what we were trying to examine did not have convenient datasets which we could run regressions on. Statistics in relation to elective surgery such as hip replacements simply did not exist in Ireland. Issues surrounding the co-located hospitals and the NTPF were shrouded by the need to protect ‘commercially sensitive’ information or safeguard a negotiating position taken by a public body such as the HSE.

Piore (2004), quoting Thomas Kuhn suggests that science has to be understood first as social practice and only afterwards as an intellectual endeavour. We carried out case studies on the areas within the service where we could make the comparison and used whatever methods were appropriate to each case. For nursing homes we had numerical statistics. For the HCP and the NTPF we had some facts and figures from public bodies such as Oireachtas committees and the Comptroller and Auditor General reports but most of the gaps were filled by interviewing key individuals. Equally to examine the public/private interface involved with hip replacements and cataract operations interviews with the surgeons was where most of our data came from.

7.4 Research Limitations

In the previous section we have outlined the contributions to the knowledge which this thesis has made. In common with all research there are some limitations which we would like to address.

First, when gathering data by the way of conducting interviews we have to accept that it will give rise to the potential for bias in the reporting. An obvious way to learn about motives, constraints, and the decision making process is to ask decision makers about them (Bewley 2002). For surgeons in Ireland there is a limited number to choose from in the first place. Then the ones who volunteer to be interviewed may
be the ones who display a more enlightened or progressive attitude. We cannot say what reasons other surgeons had for not doing the interview. Were they motivated by time constraints or does it display a less open and tolerant attitude? The answers to these questions are unknowable at this point but it is important to note that we recognize the potential for bias. Recognizing and acknowledging this potential goes some way to alleviating the potential effects of that partiality.

Second, when compiling the dataset for the study on nursing homes we use deficiency count as a measure of quality. This has been well established by other researchers (O'Neill et al. 2003, Harrington et al. 2001, Harrington et al. 2011, Nyman 1988). However deficiencies come in many forms some of which are more likely to affect the quality of the service than others. Therefore it might be preferable in future research to put a weighting or ranking system in place so that two minor deficiencies do not count equal to two major deficiencies. It is currently unknowable however if what appears to be a minor deficiency may turn out to have significant consequences if not corrected in time.

Third, more could have been made of regional variations and geographical peculiarities regarding the hip replacements and cataract operations. Considering the dominance of Dublin in relation to the rest of the country the quality and timeliness of service in different population densities would be an interesting aspect to examine but to go into this we would clearly identify individuals and institutions which we could not do under the terms of our ethics approval. Confidentiality has the disadvantage that others cannot re-check your sources to verify that the correct information has been accessed. Conversely, others could replicate the methodology with a different sample.

Whilst we acknowledge these limitations and accept that all scientific findings are treated with the caution inherent in the methods used we nevertheless believe that the data gathered in this study represents a great deal of new knowledge previously hidden from view and point to some the lacunae in data on the health services which could be greatly improved.
7.5 Implications for Public Policy

Looking at the events which have characterized the development of the Irish health service over the last decade certain issues regarding the public and the private provision of health services arise.

It is clear that the promotion of the private sector in a haphazard and arbitrary way motivated by ideology or simple cronyism bestows no great advantage on the country, damages the good public service and ultimately limits the potential of the private sector. Private operators can and will continue to target niche areas, where their management, scale and focus will have an advantage over the public sector. Examples are elective surgery and nursing homes.

Large state-run regional hospitals will continue to be the backbone of inpatient health delivery in Ireland and they will also be at the centre of educating our health professionals into the future. The way in which funds are channelled from citizens to the delivery of hospital services to all who require it will be crucial for the future development of the service. The current proposal to provide universal health coverage via private health insurance for all may give rise to increased transaction costs especially if there are many insurance companies involved.

Another issue which will impact the efficiency of our hospital system is the development of primary care centres. The Government has announced plans for 35 primary care centres which will be progressed by way of public-private partnership. This will change the status of ownership in primary care from the traditional GPs ‘rooms’ to highly equipped multi-disciplinary units complementing the hospital system. These will take the pressure off public hospitals. Public hospitals are often occupied by certain patients who would benefit from a move to ‘step-down’ facilities. But as these facilities are not in plentiful supply and in some cases older patients are not able to go home and so they stay in hospital occupying a bed which could be used for a new admission. Step-down facilities would be a great business opportunity for the private sector if an incentivized business model was in place.
As the spending on health services in Ireland now moves closer to the norm for those countries which have ‘good’ health systems we should expect that it is not beyond our capacity to rival these.

7.6 Future Research Directions

Solving the many problems and perceived problems in the Irish health system and providing a better level of service to the population will offer a constant stream of research work which is likely to continue indefinitely. Whether it is concerned with specific health issues like the effectiveness of certain types of treatment or whether it is concerned with the workings, management and practice in the health system it is unlikely that we will run out of research topics in health economics and the economics of governance and public administration.

Our dataset on nursing homes as it currently stands is capable of examining other questions such as the impact on quality of higher levels of qualification among the staff or the ratio of staff to resident. As the database is growing organically as each new inspection is added it can be revisited periodically to see if the patterns we observed were changing over time. We could also interview HIQA and the individual inspectors to get an insight into their standards and how they access deficiencies. In this way we might be able to apply a weighting to different kinds of deficiencies which could have an effect on conclusions drawn.

The development of primary care with new multi-disciplinary community centres will have a big effect on the running of hospitals and outpatient services. Primary care centres are now a major part of PPPs in Ireland and with equipment similar to a hospital and staffed both regular hours and after hours by local GPs they will be able to keep the less serious and non-emergency cases away from hospitals. Primary care development which has not been examined in this study will deserve much closer scrutiny into the future.

During the study on hip replacements our main complaint was that there was no joint replacement register to which we could refer for accurate statistics which could be combined with our qualitative results. However recently, the Irish National
Orthopaedic Register (INOR) has been established. This will be the new Irish national database of all knee and hip joint replacement surgeries to log its first patients in September 2013. This means that there will be much better information available in a year when we revisit the subject. This is a very positive development which was prompted by a number of concerns about the quality of certain hip replacement implants which required revision surgery above the average. The INOR will monitor the performance of medical devices, the activity of medical professionals who fit the devices and the institutions in which the hip replacement procedures are carried out. This will provide a rich source of data to build on the research that we have already undertaken.

7.7 Conclusion

In Ireland mixed delivery of health services will continue to feature. Choosing between public and private is not an ‘either/or’ choice. Government decisions on everything from regulation to taxation have the greatest effect on how our services perform. It is clear that an efficiently performing comprehensive public service that the population has confidence in should be central to the system. It is also clear that the private sector it particularly well suited to provide some of the services. With increasing costs and an ageing population imaginative solutions to funding need to be found but the public – the taxpayer – pays all of the costs whether immediately or in the long run. There is evidence that those countries which spend a high proportion of their GDP on health care have good systems and the people in those countries are satisfied and happy to pay for them. There is every likelihood that with well-structured incentives the Irish health service could be world class.
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Appendices
### Appendix A: Variable Descriptions (Nursing Homes)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>Ownership Type</strong></td>
<td>1 – private, 2 - voluntary, 3 - public</td>
</tr>
<tr>
<td><strong>When established</strong></td>
<td>The year that the home was established</td>
</tr>
<tr>
<td><strong>cost</strong></td>
<td>Weekly charge to the resident (proxy for cost)</td>
</tr>
<tr>
<td><strong>Log of cost</strong></td>
<td>Natural log of weekly charge</td>
</tr>
<tr>
<td><strong>action2</strong></td>
<td>Action required to remedy a deficiency on the 2\textsuperscript{nd} most recent visit</td>
</tr>
<tr>
<td><strong>action3</strong></td>
<td>Action required to remedy a deficiency on the 3\textsuperscript{rd} most recent visit</td>
</tr>
<tr>
<td><strong>action4</strong></td>
<td>Action required to remedy a deficiency on the 4\textsuperscript{th} most recent visit</td>
</tr>
<tr>
<td><strong>action5</strong></td>
<td>Action required to remedy a deficiency on the 5\textsuperscript{th} most recent visit</td>
</tr>
<tr>
<td><strong>low_depend</strong></td>
<td></td>
</tr>
<tr>
<td><strong>dependency</strong></td>
<td>Level of dependency of the resident</td>
</tr>
<tr>
<td><strong>dependency^2</strong></td>
<td>Dependency squared</td>
</tr>
<tr>
<td><strong>provinces</strong></td>
<td>Four provinces: Dublin, Rest of Leinster, Munster and Connaght/Ulster</td>
</tr>
<tr>
<td><strong>nurses</strong></td>
<td>Number of qualified nurses</td>
</tr>
<tr>
<td><strong>carestaff</strong></td>
<td>Number of carestaff – less qualified</td>
</tr>
<tr>
<td><strong>resbycare</strong></td>
<td>Ratio of residents to carestaff</td>
</tr>
<tr>
<td><strong>resbynurse</strong></td>
<td>Ratio of residents to nurses</td>
</tr>
</tbody>
</table>
Appendix B: *Ownership and Weekly Cost*

Ownership: 1 – private 2 – voluntary 3 - public

Appendix C: *Ownership and Dependency*
Appendix D: *Population Pyramid for Ireland 2011*

*Source: Central Statistics Office (CSO 2011)*
## Appendix E: List of NVivo Codes Used for Textual Analysis for Hip Replacements

<table>
<thead>
<tr>
<th>Codes</th>
<th>Sub-codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy</td>
<td></td>
<td>Freedom from interference by managers in decisions taken at the clinic by surgeons</td>
</tr>
<tr>
<td>Comparisons of performance between private and public</td>
<td></td>
<td>All comparison of public and private results, both clinical and non-clinical</td>
</tr>
<tr>
<td>Competition parameters</td>
<td>Other factors Waiting time</td>
<td>All statements about attempts to attract patients and all statements about waiting time</td>
</tr>
<tr>
<td>Credibility of reimbursement</td>
<td></td>
<td>Balance of work that surgeons are allowed to do in private under the terms of their HSE contract</td>
</tr>
<tr>
<td>Patient Selection</td>
<td>At private clinics At public clinics</td>
<td>All statements about the selection of patients</td>
</tr>
<tr>
<td>Period of hospitalization</td>
<td>Period Reason for limiting period</td>
<td>All statements about the patients’ stay at the hospital</td>
</tr>
<tr>
<td>Procedures used</td>
<td>In private clinics In public clinics Patient age and procedures</td>
<td>All statements about actual procedures used</td>
</tr>
<tr>
<td>Professional norms</td>
<td>Concerning patient selection Written recommendations</td>
<td>All statements about procedural demands within the occupation</td>
</tr>
<tr>
<td>Salary type</td>
<td>Fixed salary Performance salary</td>
<td>Text Search Query for the word salary</td>
</tr>
</tbody>
</table>

These codes are similar to those proposed by Andersen and Jakobsen (2010)
Appendix F: List of NVivo Codes Used for Textual Analysis for Cataract Operations

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting Time</td>
<td>All references to waiting times for appointments and surgery</td>
</tr>
<tr>
<td>Treatments – involvement of</td>
<td>References to the role and practice in how it affects the surgeon</td>
</tr>
<tr>
<td>management</td>
<td></td>
</tr>
<tr>
<td>Remuneration</td>
<td>How pay works in the public and private sectors</td>
</tr>
<tr>
<td>Re-admission</td>
<td>Instances of re-admission due to problems with the operation</td>
</tr>
<tr>
<td>Quality</td>
<td>Measures of quality</td>
</tr>
<tr>
<td>Professional community –</td>
<td>References to how the community of surgeons works in reality</td>
</tr>
<tr>
<td>interaction with colleagues</td>
<td></td>
</tr>
<tr>
<td>Professional choices</td>
<td>Decisions made by the surgeon in the exercise of duty</td>
</tr>
<tr>
<td>Patient selection</td>
<td>All references to how patients are selected or may be de-selected</td>
</tr>
<tr>
<td>Organization of the practice</td>
<td>Surgeons describe how the practice functions on a day-to-day basis</td>
</tr>
<tr>
<td>NTPF</td>
<td>Opinions and experiences with the NTPF</td>
</tr>
<tr>
<td>Motivation</td>
<td>What motivates doctors</td>
</tr>
<tr>
<td>Economic conflicts</td>
<td>Any issue with could be seen as an economically motivated and not in the best clinical interests of the patient</td>
</tr>
</tbody>
</table>
Appendix G: List of Questions in the structured Interview with Surgeons

**Do you work in:**
- Private clinic only
- Public clinic only
- Both public and private

**Regarding hip and knee replacements:**
- How is the work organized?
- Who determines the diagnosis?
- Who decides the treatment?
- Who decides when the patient is discharged?

**Motivation for work in the private sector:**

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Motivation</th>
</tr>
</thead>
<tbody>
<tr>
<td>To help patients</td>
<td>Patients</td>
</tr>
<tr>
<td>To give a good service</td>
<td>Colleagues</td>
</tr>
<tr>
<td>To provide consumer satisfaction</td>
<td>The public interest</td>
</tr>
<tr>
<td>The quality of medical/surgical practice</td>
<td>Professional challenges</td>
</tr>
<tr>
<td>Recognition of colleagues</td>
<td>Salary</td>
</tr>
<tr>
<td>Interesting tasks</td>
<td></td>
</tr>
<tr>
<td>Good levels of pay</td>
<td></td>
</tr>
</tbody>
</table>

**Motivation for work in the public sector:**

- Are the motives the same in the public sector?
- Describe the differences
- Is there a motivation to provide public service?
- Waiting time differences in the public and private sectors
Patient Selection:
Are there patients who cannot be treated in a private clinic?
Why?

Different acts and choices made when treating patients:
What are the typical treatment choices you face?
What are the priorities for the choices you make?
To what extent do the surgeons decide what implants and tools that should be used?
Do economic considerations influence choices made?
Does management intervene in such decisions?

Professional choices (open questions)
Can you think of clinical decisions where there is no leeway for choice?
Why?
Would that vary between different types of patients?
How about decisions where there is a number of clinical choices?
Was this always the case?
Are there within your professional area of expertise large differences between how you do things at different clinics?

Professional choices (closed questions)
Is there a particular professional community among surgeons?
How is that expressed in the daily work?
Do professional norms matter for your treatment?
In what areas?
What behaviour?
What treatment?
If no: would anybody be able to perform your work?

How would you react if someone did not live up to the norms?

Evidence

What written sources can be used to find the correct treatment?

Do you know what treatment methods work best for different groups of patients?

Was this always the case?

Who assesses and examines the different treatment methods?

Economic incentives in the private sector (or private work in a public hospital)

How does the pay scheme work at the private clinic?

Pay per hour?

Pay per service?

Differences in pay related to different choices of treatment?

Share of the surplus?

Is it profitable for you to get more patients?

NTPF patients? (Opinion of the NTPF)

Conflicts between professional norms and economic considerations

How do economic considerations affect you at your workplace?

Public and private?

Do you think about economic issues in your daily work?

Have you experienced a trade-off between economic considerations and medical considerations?

What and how?

What did you do?

Other examples?
Concepts of Quality

How do you understand the concept of quality?

Patient satisfaction?

Clinical quality?

Re-operation?

How about quality – has it suffered due to lower prices from the NTPF?

Conclusion

Are there any other conditions that have a major impact on your treatment choices that we have not touched upon?

Are all hip replacement patients on prophylactic antibiotic and thrombotic treatment?
## Appendix H: Details of Interviews Carried Out

<table>
<thead>
<tr>
<th>No</th>
<th>Subject of Interview</th>
<th>Name</th>
<th>Status</th>
<th>Date</th>
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<tbody>
<tr>
<td>1</td>
<td>General Health Service</td>
<td>Tom Hourigan</td>
<td>Ex Deputy CEO Mid-Western Health Board</td>
<td>12/11/09</td>
</tr>
<tr>
<td>2</td>
<td>General Health Service</td>
<td>Martin Duffy</td>
<td>Ex Deputy CEO Mid-Western Health Board</td>
<td>23/03/10</td>
</tr>
<tr>
<td>3</td>
<td>General Health Service</td>
<td>Stiofan DeBurca</td>
<td>Ex CEO Mid-Western Health Board</td>
<td>27/11/09</td>
</tr>
<tr>
<td>4</td>
<td>General Health Service</td>
<td>John O'Brien</td>
<td>National Director, Winter Initiative, HSE</td>
<td>20/01/10</td>
</tr>
<tr>
<td>5</td>
<td>NTPF</td>
<td>Patrick O'Brien</td>
<td>CEO, the National Treatment Purchase Fund (NTPF)</td>
<td>06/01/11</td>
</tr>
<tr>
<td>6</td>
<td>Co-location/NTPF/Ideology</td>
<td>Tim O'Malley</td>
<td>Ex Progressive Democrat TD and Minister of State at the Department of Health and Children</td>
<td>28/09/11</td>
</tr>
<tr>
<td>7</td>
<td>General Health Service/Primary Care</td>
<td>Fergus Hoban</td>
<td>Managing Director of Touchstone Healthcare Group</td>
<td>31/05/10</td>
</tr>
<tr>
<td>8</td>
<td>PPPs/Co-location</td>
<td>Kevin Feeney</td>
<td>Partner in the A&amp;L Goodbody Banking Department ( Drafter of Co-location Project Agreement)</td>
<td>29/05/12</td>
</tr>
<tr>
<td>9</td>
<td>Co-location/NTPF</td>
<td>Michael Cullen</td>
<td>Chief Executive Officer of the Beacon Medical Group (Preferred Bidder, 3 sites Co-location)</td>
<td>13/08/10</td>
</tr>
<tr>
<td>10</td>
<td>Co-location/NTPF/Management</td>
<td>Liam Duffy</td>
<td>Chief Executive Officer of Beaumont Hospital</td>
<td>13/10/10</td>
</tr>
<tr>
<td>11</td>
<td>Management/NTPF</td>
<td>Mr Brian Martin</td>
<td>CEO, Shanakiel Hospital, Sunday's Well, Cork</td>
<td>13/07/11</td>
</tr>
<tr>
<td>12</td>
<td>Management/Procedure</td>
<td>Patricia Noonan</td>
<td>Director of Nursing, Shanakiel Hospital, Sunday's Well, Cork</td>
<td>13/07/11</td>
</tr>
<tr>
<td>13</td>
<td>Co-location</td>
<td>Fergal Mulchrone</td>
<td>Ex CEO of Synchrony Healthcare (Preferred Bidder, St. James's Co-location)</td>
<td>09/03/12</td>
</tr>
<tr>
<td>14</td>
<td>Co-location/NTPF</td>
<td>Fergus Clancy</td>
<td>CEO, Mater Private Healthcare (Under-bidder Co-location)</td>
<td>28/05/12</td>
</tr>
<tr>
<td>15</td>
<td>Primary care/HSE</td>
<td>Harry Comber</td>
<td>General Practitioner, Limerick</td>
<td>08/07/10</td>
</tr>
<tr>
<td>16</td>
<td>Primary care/HSE</td>
<td>Michael Griffin</td>
<td>General Practitioner and Mid-West GP Training Centre, University of Limerick.</td>
<td>29/06/10</td>
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<tr>
<td>17</td>
<td>Primary care/HSE</td>
<td>Tom O'Callaghan</td>
<td>General Practitioner, Living Health Clinic, Fermoy Road, Mitchelstown, Co. Cork.</td>
<td>16/07/10</td>
</tr>
<tr>
<td>18</td>
<td>Hip Replacement</td>
<td>Denis Dartée</td>
<td>Consultant Orthopaedic Surgeon, Barringtons Private Hospital and Medical Centre, Limerick.</td>
<td>24/03/11</td>
</tr>
<tr>
<td>19</td>
<td>Hip Replacement</td>
<td>Finbarr Condon</td>
<td>Consultant Orthopaedic Surgeon, Regional Orthopaedic Hospital, Croom, Co. Limerick.</td>
<td>12/04/11</td>
</tr>
<tr>
<td>20</td>
<td>Hip Replacement</td>
<td>Eric Masterson</td>
<td>Consultant Orthopaedic Surgeon, Regional Orthopaedic Hospital, Croom, Co. Limerick.</td>
<td>20/04/11</td>
</tr>
<tr>
<td>No.</td>
<td>Procedure</td>
<td>Name</td>
<td>Institution</td>
<td>Date</td>
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<td>----------------------------------------------------------------------------</td>
<td>--------</td>
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<tr>
<td>21</td>
<td>Hip Replacement</td>
<td>David Borton</td>
<td>Consultant Orthopaedic Surgeon, Hermitage Medical Clinic, Old Lucan Road, Dublin 20.</td>
<td>13/04/11</td>
</tr>
<tr>
<td>22</td>
<td>Hip Replacement</td>
<td>Paraic Murray</td>
<td>Consultant Orthopaedic Surgeon, The Galway Clinic, Doughiska, Co. Galway.</td>
<td>19/04/11</td>
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<tr>
<td>23</td>
<td>Hip Replacement</td>
<td>Derek Bennett</td>
<td>Consultant Orthopaedic Surgeon, Mayo General Hospital, Castlebar, Co. Mayo.</td>
<td>28/04/11</td>
</tr>
<tr>
<td>24</td>
<td>Hip Replacement</td>
<td>James Harty</td>
<td>Consultant Orthopaedic Surgeon, Consultants Private Clinic, Bishopstown Road, Wilton, Cork</td>
<td>24/05/11</td>
</tr>
<tr>
<td>25</td>
<td>Hip Replacement</td>
<td>Peter Keogh</td>
<td>Consultant Orthopaedic Surgeon, Cappagh National Orthopaedics and Hermitage Medical Clinic</td>
<td>25/05/11</td>
</tr>
<tr>
<td>26</td>
<td>Hip Replacement</td>
<td>Paddy Kenny</td>
<td>Consultant Orthopaedic Surgeon, Cappagh Hospital, Connolly Blanchardstown and The Hermitage</td>
<td>16/06/11</td>
</tr>
<tr>
<td>27</td>
<td>Cataract Extraction</td>
<td>Gerard O’Connor</td>
<td>Consultant Ophthalmic Surgeon, Cork University Hospital Wilton, Cork</td>
<td>23/09/11</td>
</tr>
<tr>
<td>28</td>
<td>Cataract Extraction</td>
<td>Patricia McGettrick</td>
<td>Consultant Ophthalmic Surgeon at St. Francis Hospital, Mullingar, Co. Westmeath</td>
<td>24/09/11</td>
</tr>
<tr>
<td>29</td>
<td>Cataract Extraction</td>
<td>Tom Stumpf</td>
<td>Consultant Ophthalmic Surgeon at Whitfield Clinic Cork Road Waterford</td>
<td>26/09/11</td>
</tr>
<tr>
<td>30</td>
<td>Cataract Extraction</td>
<td>David Kent</td>
<td>Consultant Ophthalmic Surgeon at The Vision Clinic Barrington’s Hospital Georges Quay Limerick</td>
<td>27/09/11</td>
</tr>
<tr>
<td>31</td>
<td>Cataract Extraction</td>
<td>Paul Moriarty</td>
<td>Consultant Ophthalmic Surgeon at Royal Victoria Eye &amp; Ear Hospital Adelaide Road Dublin 2</td>
<td>12/10/11</td>
</tr>
<tr>
<td>32</td>
<td>Cataract Extraction</td>
<td>Timothy Horgan</td>
<td>Consultant Ophthalmic Surgeon at Kerry General Hospital, Tralee</td>
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</tr>
<tr>
<td>33</td>
<td>Cataract Extraction</td>
<td>Robert Acheson</td>
<td>Consultant Ophthalmic Surgeon at Mater Private Hospital, Eccles Street, Dublin 7</td>
<td>02/11/11</td>
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