# Behind the Croke Park deal: the politics of ‘transformation’

The latest targets from the Department of Health read like a script from Alice in Wonderland—all emergency patients are to treated and discharged, or admitted to hospital within six hours by the end of this year!!

I noticed that, while this year’s budget is down, ‘policy and corporate support’ is up—by 3 per cent, but funding for older people is down, by 8 per cent.

Beaumont Hospital recently announced that it was closing one operating theatre a month on a rolling basis. Yesterday the HSE admitted that it might have to close the Lourdes maternity unit altogether because of a shortage of doctors. Despite the fact that in many specialties we have a dire shortage of medical consultants, plans are afoot to slash the number of doctors in training by 900—around one quarter of the current total. By last December, almost 2 500 graduate nurses had applied for work abroad because of the ban on recruitment. Our GP ratio is one of the worst in

Europe, our bed to head ratio – the number of acute public hospital beds per head of population—one of the worst in OECD countries.

Not content with this level of scarcity, the government plans to close small-to-medium sized public hospitals across the country. Mullingar Hospital is one of them, as is St Luke's, Ireland's specialist centre for cancer care for many decades…That Bill has just gone through its second stage in the Dáil.

Last week the HSE denied that 24 beds had been closed permanently at Naas General Hospital. These are just some of the 1 200 public hospital beds closed across the country, according to the nurses and midwives' union. They say the numbers on trolleys are now at their highest since 2007, when the body count was declared a 'national emergency'.

HSE also denies plans to cut hospital A&E department to 'office hours only'. We are just two weeks away from D-Day, when 'junior' hospital doctor contracts expire. Only on 1 July will it become clear if Naas Hospital will continue to have a full-time A&E service. Hospitals in Ballinasloe, Castlebar, Tralee and Letterkenny are in the same boat.

We are now facing the biggest closure of beds and services since the public hospital asset-stripping of the 1980s. Our public health system is being stripped out by stealth under the banner of ‘transformation’. Like ‘reconfiguration’ and ‘reform’, these are weasel words for Government bed-cutting programmes.

No country in the developed world has eliminated its tier of general hospitals, as Ireland proposes to do. ‘Moving’ care from hospitals to the community is another mantra that, like ‘centralisation’, is predicated on mass hospital closures. This is an untried and untested experiment. There is no good evidence to support HSE’s claim that primary, community and emergency services can safely replace hospital inpatient care.

Sweeping claims have been made for centralisation. Larger volumes lead to better outcomes, we are told. But there is no good evidence to support these statements. No quality data exist to support the centralization of common cancers, for example. Even the claim, and we hear it ad nauseam, that larger volumes of surgery lead to better outcomes for patients is wafer-thin, except in the case of a very small number of very complex procedures[i].

Our health services are being restructured on a daily basis, but this is not driven by evidence. It is driven by ideology. Nurturing for profit companies requires public sector pruning. A recent report commissioned by HSE, for example, sets targets for bed-cutting. Public patient beds are to be cut from under 13 000 to under 8 000 by 2014[ii]. This—the Hanly Report in action—represents a total bed loss, nationally, of over one third of our national bed stock. Over 4 700 beds are set to close. Is this part of the deal signed up to by the unions in the Croke Park agreement?

The Teamwork Report on the north-east has been adopted as a 'template' for restructuring the entire health service. Teamwork, a Bolton accountancy firm that played a leading role in devising PPPs in the British NHS, is one of the main architects of the privatisation of our health services. They came up with a new version of the Hanly Report, a de luxe model. In the north-east, for example, Teamwork proposed that all five public hospitals in the region should effectively close in the interest of so-called patient safety, and be replaced by a new regional hospital.

Implementing the Hanly-Teamwork template will effectively close around 40 of our 53 acute public hospitals. Hanly proposed a half a

million population threshold for a ‘viable’ in-hospital A&E unit. Implementing that yardstick here will leave each hospital A&E ‘serving’ a geographic area of *2 300 square miles*[iii].

Health 'reform', in this context, is a danger to public health. The so-called transformation—or decimation—agenda will leave hundreds of thousands of people two hours’ drive or more from hospital inpatient care, at increased risk of death or permanent disability, because of the mass closure of public hospital A&E and maternity units.

Patients also risk being out of pocket. The rules governing health eligibility are being re-written. The 1970 Health Act is now up for grabs: a new Health Bill is set to come before the Dail next autumn. The much-touted shift from hospital to community care will bring new charges. The new corporate primary care centres will charge for services once provided free of charge to public hospital outpatients.

Teamwork brought restructuring to a new level. Our public health system is being hollowed out and replaced with an internal market. Just like Magggie Thatcher did in the 1980s with the British NHS. Health services will be traded just like any other commodity in this brave new world.

American health care corporations have long reaped huge profits in planned (or elective) procedures, and in areas such as radiology, pathology and chronic diseases[iv]. These are the new niche markets that you now see opening up in Ireland. Reassuringly, the new niche markets are labelled 'clinical networks'[v]. Reassuringly, they are labelled 'clinical networks'[vi]. Who could be against a clinical network?

You have already seen what has happened in the area of pathology. This is an area that is so profitable that private medical laboratories are referred to as 'money machines'. Smear testing is the first of the mini-niche markets in pathology to be privatised. But outsourcing cervical cancer testing has had a disastrous effect: patients are now at risk of having to undergo more invasive testing, needlessly, because US lab services are not as good as Irish ones. The Quest contract has also dented our public laboratory services. Around 60 scientists have had to be redeployed as a result. The lab at St Luke's was among the first to close.

Reassuringly, the new niche markets are labelled 'clinical networks'[vii]. Cancer was the first chronic disease to be brought to market in Ireland. Now, cardiovascular disease—heart disease and strokes—is to follow.

Last week the Government launched its ‘new’ cardiovascular health policy. This is a recipe for further cuts, as some hospitals will lose their cardiac services. This, we are told, will provide us with a ‘world-class’ service.

The reality, of course, is that cardiovascular services are being marketised, or bundled together—to be outsourced to the lowest bidder. *All* services for cancer, for example, be they primary/community, hospital or continuing care are being bundled together, and these bundles will form the basis of commercial contracts. Think of the telecom providers who sell integrated packages that consist of line rental, broadband, and a number of calls, all for a fixed sum, and you get the idea.

These contracts are known as ‘service level agreements’: they will be given to allcomers, including private for profit hospitals. So public monies that were, until now, earmarked for public hospitals will in the not-too-distant future go to private sector providers. This is how the market works. Meanwhile, costly and unprofitable services, such as A&E and intensive care, will left to publicly funded hospitals to provide.

Other, more lucrative, services will be outsourced. This is what resructuring means. We are looking at American models of ‘chronic

disease management' in action. Services for other major chronic diseases, such as diabetes, are to go the same way.

To market.

Implementing this American model will see cancer services, and others, removed from the control of public hospitals. The new specialist breast cancer centres, for example, will be 'separate entities', while the 'national cancer control programme' (which has just got a new chief) is actually 'a separate *businesss* unit within HSE"[viii].

Public hospitals face destabilisation and downgrading. Implementing the cancer strategy will fragment and dis-integrate existing public hospital services, not least by removing some of their principal sources of business. All public monies hitherto spent on cancer care are to be made available to the new cancer business unit. It will have executive control over every aspect of cancer care, including the appointment of medical consultants. It will also own and manage the six new radiation oncology centres being built through public-private partnerships.

One of the units main functions is to create 'competition'. It will do this by creating an new internal market, by running what amounts to a state

auction for cancer services. At this auction, private for profit entities will bid against publicly funded hospitals for cancer contracts. And, if you doubt me, read the national cancer strategy: it provides for State contracts to be given to private sector ‘providers’[ix], for public monies to be rerouted to commercial companies.

Public patients are already being treated by a variety of 'providers', including domestic and overseas companies. Under Mary Harney’s leadership, a double standard prevails, one for the public sector and another for the private. Many, if not all, of these for profit cancer facilities are significantly smaller than many of those that have been withdrawn from our public hospitals. So much for the national standards—for the rules on patient volumes—that were used so ruthlessly to close public cancer services.

Research on for profit health care is negative: health services run for profit are less safe and cost more to provide. Death rates are higher in for profit institutions. The profit motive leads to over-testing and over-treatment, increasing the risks for patients[x]. Private cosmetic surgery clinics have proved particularly problematic in Ireland. You may remember one, Advanced Cosmetic Surgery, wound up after being bought by a builder. Advanced ran into difficulties following the death of

a woman who had had gastric banding. At least seventeen other legal actions against the clinic are pending.

Nursing homes overtook golf courses as the investment of choice during the boom. Deficiencies have been found in a number of private for profit nursing homes in recent years: inspectors have complained, among other things, of low staffing levels. This is a classic complaint levelled at private for profit health facilities. The pressure to cuts costs may put patients at risk.

General practitioner services in Ireland now look set to be corporatised: PPPs are being used to build the new primary care centres. We 'went to the market and let the market decide', a HSE bureaucrat proudly told a private health care conference in Santry's Plaza Hotel in 2008. Well, we saw what happened in banking when we let the market decide….

The Government's policy of privatisation, implemented through tax incentives, outsourcing and public-private partnerships, has been remarkably successful. Private for profit hospitals are shooting up all over the country, uncontrolled, like ragwort. If all of the eight co-located hospitals get built here as planned—although this there is some doubt over this—along with the 13 tax-fuelled investor-owned hospitals,

entities, around half[xi] of our acute hospital beds (excluding long-stay and psychiatric), could soon be for profit, in one form or another.

Business plays an important role in the marketisation of health care. Personal relationships have a considerable influence on political decisions and policy-making in Ireland[xii]. Actors from the private sector, who may reasonably be expected to represent private sector interests, have been given leading roles in health policy-making. The group that produced the *Hanly Report*[xiii] in 2003, for example, was chaired by a prominent businessman, David Hanly, who was repeatedly flagged in the media as an 'independent' chairman. His company, Parc, ran a private hospital in Baghdad.

Private interests are facilitated by the existence of a revolving door between the public and the private sector. The same consultancy firms work for both the public and the private sectors. Unless you believe in Chinese wall, and I don't, then this gives rise to conflicts of interest.

The privatisation of public administration is reaching ridiculous lengths. The decision on the location of the planned new hospital in the north-east was outsourced to a firm of private consultants, the Health Partnership. The firm has two principals: one of them is Noel Daly, a former CEO of

An Bord Altranais. His firm has advised on at least seven developer-led health care projects in Ireland, including the Vista Primary Care Centre in Naas. Entrusting such a sensitive decision as where to locate a regional hospital to a company with such a strong profile in the private sector raises the possibility of conflicts of interest. In the event, the Health Partnership decided to locate the new hospital in Mr Daly's own home town.

And because Ireland is so small, leading actors in public policy-making may be simply related to industry leaders in the private sector. The forum that developed the cancer strategy, for example, was chaired by a leading professor, Paul Redmond, of Cork University Hospital. Paul Redmond is a brother of UPMC Beacon Medical Group co-founder, Dr Mark Redmond. Such close connections give rise to conflict of interest queries. Coincidentally, of the eight hospitals selected as specialist cancer centres by the cancer forum, five had been designated for co-location and in three of these, Beaumont, Cork and Limerick, UPMC was, and is, the co-location operator.

Health 'reform' is synonymous with privatisation. It is driven, not by evidence, but by ideology, belief in a model that has failed spectacularly in the last couple of years, the market model. Privatisation requires the

closure of public services. Strategic management has produced reports and devised tactics, such as the cancer and chronic disease stratagems, all dovetailed to secure public service cuts. These cuts create business opportunities for powerful interests that serve commercial needs, not patient welfare.

Our health system, I believe, is being recast in an American mould. We are witnessing a massive experiment driven, not by science, but by greed. The walls of the public health system are being pulled down from within. Cost cutting is now being used to drive transformation, and transformation, as we have seen, is a Trojan Horse crammed with private for profit soldiers.

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[i] Catherine McNamara 2004 op cit, 7-9.
[ii] PA Consulting 2007 *Hospital Bed Capacity Review: A Preferred Health System in Ireland to 2020 Detailed Report*. Health Service Executive, Dublin, 150. [Online] Available: http://www.hse.ie/eng/Publications/Hospitals/PA_Consulting_Report_-_A_Preferred_Health_System.pdf.

[iii] Catherine McNamara 2004 *The Hanly Report: a critique,* 10 [Online] Available: http://www.saveourhospital.com.

[iv] Jerry Mansmann 2006 *The Business of Health*. Berkeley Court Hotel Dublin 5 Apr. In Marie O'Connor 2007 op cit, 202-5. Planned surgery, diagnostics, cancer and chronic diseases are the areas to target, according to the Nations Healthcare CEO. The transnational healthcare corporation has formed a strategic alliance with UPMC.
[v] Teamwork Management Services Limited 2006. *Improving Safety and Achieving Better Standards: an action plan for health services in the North East*.Teamwork

Management Services Ltd, Bolton.

[vi] Teamwork Management Services Limited 2006. *Improving Safety and Achieving Better Standards: an action plan for health services in the North East*.Teamwork Management Services Ltd, Bolton.

[vii] Teamwork Management Services Limited 2006. *Improving Safety and Achieving Better Standards: an action plan for health services in the North East*.Teamwork Management Services Ltd, Bolton.

[viii] Maureen Brown 2008 *Health Manager Journal* 11 Feb. [Online] Available: http://www.hmi.ie/NewsArticles/feb_8_tom_keane_interview.pdf

[ix] National Cancer Forum 2006. *A Strategy for Cancer Control in Ireland* [Online] Available:http://www.hse.ie/eng/Publications/Public_Health_/National_Cancer_Control_Strategy.pdf.

[x] ibid, 225-6.

[xi] In Marie O'Connor 2007 op cit, 326-7. These numbers may require a slight downward adjustment, if public hospitals with co-located entities are prohibited from contracting with private health insurers.

[xii] Transparency International Ireland 2009 *National Integrity Systems Transparency International Country Study Ireland 2009, 16.* The report found high levels of legal or lawful corruption, with decisions influenced, to an undue degree, by personal relationships, patronage, political favours and political donations. [Online] Available: http://www.transparency.ie/Files/NIS_Full_Report_Ireland_2009.pdf
[xiii] *Report of the National Task Force on Medical Staffing* (otherwise known as the Hanly Report) 2003. Stationary Office, Dublin.