SUBMISSION FOR EXPERT REVIEW GROUP EXAMINING PRIVATE PRACTICE IN PUBLIC HOSPITALS

ELIGIBILITY, ACCESS AND EQUITY

All women and babies who attend our services currently are entitled to publically funded care. However more than 40% of the population choose to purchase private health insurance cover.

In obstetrics and neonatology as these are acute demand driven services access to the service is determined solely on need and access is not influenced on whether a woman has or indeed doesn't have health insurance.

In my hospital more income is generated in our gynaecological services from those who have private insurance but choose to attend the public clinic and present as public patients for procedures than from those who attend in a private capacity and have procedures in a private capacity. This is entirely by the woman's choice.

In my practice I have a combined waiting list for both public and private patients and their placement on the list is based on clinical need and where is there capacity on a list it's entirely on a first come, first listed for surgery basis regardless of status.

It is worth noting that with the increasing number of insurance plans available many of those with private insurance will not have cover for private hospitals. This will limit access and add to the public waiting list. As will the propensity of private hospitals to "cherry -pick" the less complex cases, again limiting patient choice and access as many services currently available to private patients will only be available in the public system. This will increase costs to the public system.

A good example of this lack of choice is in obstetrics where there is no provision for private care in private hospitals since the closure of Mount Carmel in Dublin and the amalgamation of the maternity services in the Bons Secour Hospital Cork with CUMH.

In our hospital approx. 13% of women choose private care with approx. a further 10% choosing semi-private care. The Maternity strategy emphasises woman's choice and the

removal of private maternity care form public hospitals will disenfranchise up to one quarter of women who access our service.

It should be noted that in the NHS there are many and indeed an increasing number of examples of inequality of care depending on address and poor access to care due to increasing waiting lists for consultations and procedures, which are impinging on patient care and staff morale. The exodus of senior consultants from the NHS at an increasingly early age is evidence of same.

CURRENT AND FUTURE FUNDING ARRANGEMENTS

Private income generated from our services amounted to more than 12 million euros in 2016 and greater than 10 million euros in 2017. Relative to the entire budget this represents a greater percentage of income than the percentage of patients who generate this income. Taking private practice from the public system will lead to budget deficits as private patients are net contributors to the income of the hospital. Removing private practice will generate an even greater budget deficit particularly in Obstetrics are there is no facility for delivery of Obstetrics in private hospitals, as these women will lose the choice to attend in a private capacity with subsequent loss of income for the hospital.

Future funding models will have to be genuinely activity based and not allocation as at present.

LEGISLATIVE AND LEGAL ISSUES

The removal of private practice will generate legislative and legal issues in that each consultant currently has an individual contract with the employer. That implies that a blanket pronouncement will invariable result in a breach of contract. Apart from type A contract holders all other contract holders have as part of their contract a facility for delivery of private care in their public hospital. The varies between an 80:20 to a 70:30 ratio. To complicate matters further in my hospital we have 7 different consultant contracts (Type A, B, B*, C, Academic, Type 2 and a Master's contract).This is in addition to consultants having split contracts between other public hospitals and academic institutions.

OPERATIONAL MATTERS INCLUDING SPECIALIST SERVICES

Taking private practice from public hospitals will lead to less access to patients to consultants under the new setting as the consultants will invariably be spending more time off site.

Private hospitals will be selective in the cases seen and will not deal with more complex care or cases requiring more specialist care.

RECRUITMENT AND RETENTION OF PERSONNEL

The FEMI cuts have led to a crisis in recruitment. It is well documented the number of unfilled consultant posts nationwide and also the small number of applicants for those posts that are deemed attractive to potential consultants.

The salary for a new consultant after 5-6 years of university, a training scheme of 7-8years, a possible higher degree of 2 -3years duration and a possible fellowship of 1-2 years is not attractive. On that salary alone a new consultant would not be able to afford a mortgage for an average priced house in any of our cities.

These are highly intelligent people who will wish to work to live and not vice versa.

In addition there is minimal support for consultants in the system currently let alone newly appointed consultants with many in my speciality having no access to a secretary, a theatre list or even an office.

The previous attraction of a potential private practice being denied to new consultants will only exacerbate this already critical situation and will not attract the leaders that were traditionally attracted to medicine in Ireland. It will only when it's lost will this be realised with a corresponding detrimental effect on patient care.

PRACTICAL APPROACHES TO REMOVING PRIVATE PRACTICE FROM PUBLIC HOSPITALS INCLUDING TIME FRAME AND PHASING

The removal of private care from the public system is driven by a certain ideology which is not prepared to look at how the present system could be improved.

One suggestion is that all consultants will be monitored in their provision of their contractual agreement to provide service to the public patients and where this is lacking then access to private practice will be suspended.

If private practice is removed from public hospitals then the CIS will need to cover private care in private hospitals for consultants whose contracts have been breached.

Compensation will need to be paid to those whose contractual obligations cannot be honoured.

Improved conditions of employment and remuneration will need to be negotiated to attract high calibre consultants.
In the case of obstetrics private hospitals will have to provide private care and this has significant contractual and insurance implications.
The Health budget will need to rise to accommodate the loss of private income from the public hospitals.
This proposal will lead to less choice for women – what a shame that **Quality and Fairness** was never implemented.

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