Submission Public/Private review

Doris, John to: 'IRGPrivatePublic@health.gov.ie' 23/01/2018 12:33

To Whom it concerns,

Thank you for the opportunity to express my views regarding the issue of private work within the public system.

I am a consultant Ophthalmologist with a specialist interest in Vitreoretinal surgery and currently hold a B contract that permits 20% private work within the hospital. I currently work within these parameters.

My work involves a lot of emergency surgery and my primary aim is to provide easy access of all my patients to emergency surgical treatment irrespective of their means to pay.
I like to think I put my patients needs at centre of all my decision making.

I have done all my training outside Ireland within the United Kingdom's NHS and this has given me a unique perceptive.

In Manchester Royal Eye Hospital and Moorfields Eye hospital London which are both NHS hospitals public and private patients are treated within their walls. The public system is kept separate from the private work under the same roof which I feel is appropriate. The monies generated by private work within the hospitals is reinvested in the public system. Consultants are allocated private theatre and clinic space. They are encouraged to use hospital facilities in order generate additional income for their perspective hospitals. There is no restriction on them performing private work outside their public commitments.

I would like to express my view as to how I see the public/private health system within Ireland operates.

The HSE funds the public health system in Ireland. There are two very different types of public hospitals HSE owned hospitals and the voluntary Hospitals.

The voluntary hospitals are usually run as non-profit organisations which have their own governance and financial structures. They receive a block grant for the HSE work that they do which is negotiated from central HSE. The HSE owned hospitals are run by HSE itself with local, regional and central governance structures. The voluntary hospitals have some financial autonomy and thus have a competitive advantage over the public HSE hospitals.

Ireland also has private hospitals run by private companies. They exist to supply health care to people who wish to be treated for various medical conditions outside the public hospitals. Most patients who attend these hospitals have paid into medical insurance schemes. Patients perceive that they will be treated quicker and receive medical treatment which is safe adhering to international standards of quality of care in accommodation a kin to a 4 star hotel. These hospitals need to keep a close eye towards profitability. Very few private hospitals have the ability to provide the full spectrum of emergency medicine as it simply isn't profitable and rely mostly on scheduled or elective procedures.

Private work can also be done within the public hospitals. In fact most HSE consultant contracts permit up to 20% private work. Patients receive timely treatment from their named consultant. The insurance companies in general pay less for public hospital treatments. The monies generated are significant revenue to the public hospital system and pay for staff among other things.

The majority of new consultants are under B contracts and cannot perform surgical treatments outside their assigned public hospitals. Thus there is a probability that some of the newer surgical techniques are now not available to private patients outside the public hospital domain. Public consultants have been scrutinised by their peers prior to appointment as part of the HSE selection process. The same checks and balances may not in place universally within the private sector.

The insurance companies are also in the business of maintaining profits. Most insurance policies have become more expensive year on year. These increases are partly inflation adjustments but they are also due to increases in private claims and increasing costs of delivering health care. It is in the interests of the Irish population to have a choice of health insurance provider to maintain an element of market competition and a fair price.

In recent years the private sector has been used by the HSE to provide public hospital care for those waiting on long public waiting lists. This work is organised through the NTPF who can assign moneys for individual treatments. The NTPF can also make use of public hospital facilities for this work. The public NTPF hospital work is done in public theatres and day case wards which are not been used for example over weekends by staff who are working outside their contracted hours. The NTPF negotiates with both the private and public sectors for this work. Usually the public sector providers will provide a quote which is very significantly less than that of the private sector.

On the face of it the NPTF provides a needed public service designed to deal with spikes in demand. However the scale of the public waiting list is beyond the NPTF solution which works out excessively expensive without sorting the problem. The NTPF is a short term sticking plaster which currently is been used as a long term solution and as political emergency valve option to calm a worried population.

We need to do root cause analysis. The issue is a lack of investment in the public hospitals. Insufficient theatre space and insufficient staff. The public system needs capital investment. In fact we seem to have squandered the opportunity of putting together a realistic 10 year plan. I feel we should set aside each year a significant sum to fully finance and sort out each public service capacity issue in a 10 year sequence. We need to prioritise the clinical areas. Cataract and urology waiting lists would be an obvious first step. Both these areas involve high volume surgeries in day case settings which will have a large impact on the waiting lists and require relatively small capital investments. There capitalisation will also have indirect knock on effects increasing the pool of on-call staff thus reducing the need for agency staff.

The private health care system in Ireland is not truly a private health system as it is in effect a publicly subsidised enterprise. The amounts of money currently paid into insurance plans do not even come close to the true cost of health care. It is a top up system. If we want a public system in 20 years' time we need to realise that we are currently cannibalising the public system. The danger of this is that we will soon have to pay beyond our means for private health care as costs rise. If we have another downturn there will be additional pressures on the public system which is already at breaking point.

The calls for the removal of private health care within the public hospitals in my mind is insane. We all need to pay more for health care and those who can pay for private health care top up plans help to keep costs down. If we move all private health care to private hospitals it will mean a significant gap in hospital budgets. No means of paying for the capital plans outlined earlier. We will also have to lay off staff.

Vulture funds will then prey on our private health care system. The true cost of health care will be reflected in our increased insurance costs. The current Private health care system is in some way protected from vulture capitalists as the private work done in our public HSE hospitals is not for profit. Private consultants will be put under extreme pressure to provide more for less. There will be a race to the bottom. Consultants will be forced to leave the country bringing their skills with them. In my mind we need to ensure that most of the private work is done in the public hospitals in private wings. In this way we can pay for additional staff and encourage consultants back to Ireland.

We may then be in a position to provide and develop a successful international health care industry which we so badly need to encourage in this country. This lucrative emerging market could pay dividends to the public purse.

There is no doubt that the public health system could be more efficient. We do need to measure and reward activity. We also need to assess patient outcomes and maintain our humanity.

Our health system is a complex beast and a radical change is needed.

It is now time for everyone to wake up and see this as a 10 year non-political issue.

As a final comment I feel that the idea of hospital groups is a good concept but currently they have no fiscal power and require central HSE financial approval for any projects. The voluntary hospitals set uncomfortably within this model as they are not owned by the HSE and have financial autonomy. The anomaly of University Hospital Waterford also sets uncomfortably and will need to be addressed if the groups are to survive. University Hospital Waterford sits within the South South West group and has a catchment of around 5000,0000 people but only 200,000 live in the groups catchment. The other 3000,000 live in the Dublin East group. If fiscal power is devolved to the groups then how will this hospital be funded? Perhaps we need to readjust the groups to reflect the fiscal realities rather than political aspirations.

Kind regards

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