SOUTH INFIRMARY-VICTORIA UNIVERSITY HOSPITAL
Old Blackrock Road, Cork

Department of Anaesthesiology

A Teaching Hospital of
University College, Cork

Tel: (021) 4926100
Fax: (021) 4310153
E-mail: anaesthesia.consultants@sivuh.ie
Website: www.sivuh.ie

Dr. Stephen Mannion,
Dr. Anthony Hennessy
Dr. Clare Murray
Dr. Jawad Mustafa
Dr. Michael O'Sullivan, Chairman
& College Tutor

8th February 2018.

RE: Submission on the Independent Review of Private Practice in Public Hospitals.

Dear Mr. Toomey,

Our Department notes the following with respect to the proposed removal of private practice from public hospitals as outlined in the Sláinte Care report.

Overall our Department believes this will have significant, serious, longterm and unforeseen adverse effects on patient care for public patients at this hospital.

Patient Care: Our Department delivers 45% more anaesthesia theatre hours than required under our contractual obligations. These hours do not include pre-operative clinics, pain service or care of ill patients in our post surgical care unit. Nor does it include non-clinical tasks. This extra service is delivered free to the public health service because we are able to care for some private patients in these 45% extra hours. Removal of private practice will result in all these hours being lost as they are outside our contractual requirements. As an example of a public only hospital and the effects on workload and consultant staffing: Hôpital Lapeyronie, Montpellier, France is one of the largest public surgical and trauma units in France. Of 42 permanent consultants, there are 7 vacancies unfilled. Numerous consultants have left in recent years to work elsewhere. All the anaesthesia and surgical trainees are planning to work in the private sector in France, a sector that accounts for 50% of all surgery done in France and 60% of all cancer work. Consultant posts that can be filled are filled by doctors from outside France. The workload in this hospital was one-third the workload of a similar public hospital in Ireland which allows private practice - Cork University Hospital. All staff, including nurses stated that the number of cases done in the local private hospitals was twice that of Hôpital Lapeyronie and earning potential for consultants was 2-3 times higher in that private sector.

Recruitment and retention of consultant staff: As our contracts forbid us from working outside our hospital, removal of private practice would reduce our income. In order to maintain our livelihood, a number of consultants have indicated they would leave the public only hospital entirely, while the remainder have said they will expect compensation and new contracts to allow them to work off-site. Our Department will be unable to recruit highly qualified consultants to our public hospital as candidates will be enticed by an earning potential 2 to 3 times greater in full-time private practice or abroad. This will result in fewer public patients being able to be treated as our Department would have insufficient staffing levels. As examples recently of the effects changes to consultant working terms and conditions have had on our hospital: one of the 4 radiologists left to work in a private hospital, 3 of our 8 orthopaedic and 1 of our 5 plastic surgeons have changed to a Type C contract, we had only 1 applicant for a prestigious Head & Neck Cancer surgical consultant job and we have had great difficulty recruiting for our last 2 vacant radiology consultant posts and also for a recent ENT consultant job.

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Funding for delivery of care: Our hospital is already under-resourced from the HSE even with the current income from private patients. Our Department has to constantly battle for essential equipment or do without. Our Department does not believe that these funds will or can be replaced, in full or in part, if private practice is removed, resulting in poorer levels of service. The costings in the Sláinte Care report have not been independently verified.

Specialist surgical services: As a surgical hospital we have highly specialized surgical services. These services are often run by only 2 specialist consultants. If public hospital work becomes unattractive to surgical consultants then these specialized services, which are already undermanned will suffer and possibly become unavailable in the public only hospital.

Equity & access: Our professional role is to provide expert anaesthesia care to our patients regardless of whether they are public or private. The reality is that removal of private practice will require a significant decision by our consultants on whether to stay in the public system or leave. As has been seen in An Garda Síochána, the loss of senior people from an organisation can result in catastrophe outcomes. This is the likely scenario facing public patients as the most senior and qualified consultants will be highly sought by other institutions both nationally and abroad, who can provide better working terms and conditions. Public patients are therefore the only losers in this misguided attempt to improve equity and access. Equity and access to hospitals will be improved by providing more hospital beds, more operating theatres, more critical care beds and making it attractive for consultants to want to work in a system that already has over 400 vacancies.

Summary: Overall, the removal of private practice from public hospitals must be able to demonstrate conclusively that patients (both public and private) will get better care. Our own assessment of the impact of such a move on our hospital clearly demonstrates that patient care will worsen. Similar to what occurred in Australia when private patients were initially removed from their public system a number of decades ago, health premiums will rise, patients will drop health cover, the same or greater numbers of patients will now attend the public hospital but the hospital will have reduced income and so patient care will worsen. Consultants in Australia mostly opted for a move to the private system with the public hospitals eventually having to buy back their services at increased costs.

Conclusion: We believe patients should be treated in our hospital on the basis of clinical need regardless of being public or private. We do not see the recommendations regarding hospital care contained in the Sláinte Care report achieving this and in fact we believe these recommendations will in fact worsen overall patient care in our public system.

Thank you for accepting our submission,

Yours sincerely,

Dr. Michael O'Sullivan

Dr. Stephen Mannion

Dr. Anthony Hennessy

Dr. Clare Murray

Dr. Jawad Mustafa.