Dr. David O'Keeffe FRCR FRCPI FFRRSCI
Consultant Radiologist
[redacted]

Tuesday 16 January 2018

Submission to IRGPrivatePublic@health.gov.ie

Dear Sir/Madam,

I write in regard to the request for submissions on the removal of private medical practice from public hospitals.

I write as a Consultant Radiologist of 25 years standing, a former President of the Irish Hospital Consultants Association (2008 when the Consultant Contract was agreed), a former Clinical Director and former acting General Manager of Galway University Hospital and Clinical Director (2010-2013). I have trained in England and America.

I firmly believe that the proposal is not in the interests of patients in the public health care system.

Department policy for many years has been that patients may elect to pay or use their insurance for medical care if they can afford it and choose to. In return they receive direct personal care from their consultant rather than a member of his or her team, in a training post. Their accommodation may be private, semi-private or general ward depending on availability and the acuity of their condition.

A common waiting-list is now a sine qua non for all public hospital elective admissions, diagnostics and out-patient care.

There are many specialty areas where there is simply no private hospital service or realistic capacity. Obstetrics and neonatal care are the most obvious examples, and treatment in the eight designated cancer centres is another. For the most part the private hospital service in this country has chosen service delivery on a nonemergency basis in a limited number of non-acute clinical conditions and for a limited number of types of surgery of up to medium complexity.

Most private hospitals operate at the equivalent of level 2 or 3 hospitals in the public health system

24 /7 emergency care and care for acute myocardial infarction and stroke is simply not available in the private health care system.

There is a limit place by insurers on the time the insured patients may spend in a private hospital. When the patient has exceeded his or her length of stay or the condition becomes too complex the patient will be transferred through the emergency department to the public hospital.

The appointment and retention of consultants has been well ventilated. The Department of Health's insistence in choosing to restrict consultants from working extra contractually other than if they possess type C contracts under the 2008 contract has been a significant deterrent for consultant applications. (The current type A -public only contract was abandoned by the department between 1997 and 2008, a dramatic inconsistency!)

20 years ago when a post was advertised for a consultant radiologists the were typically 8 to 10 extremely well-qualified applicants who were practising consultants either in England or North America. Now we're lucky to receive one or two applicants and frequently they are not qualified for appointment or even an interview.

Salary levels in Ireland are not internationally competitive, particularly when reduced by up to 20% to allow for private practice.

This when combined with the medical legal and regulatory complexity of practice is a deterrent to the return and retention of highly qualified younger doctors.

If private patients are removed from public hospitals the cost of private practice and private health insurance will rise inexorably since private hospitals will have to gear up to performing more complex work than they currently do. One need only look at the cost of health insurance in the United Kingdom and United States of America for comparators. It is likely that the public system will increasingly subcontract it's diagnostic radiology and laboratory work to the private sector.

It is also likely that surgery will be subcontracted to the private sector under public hospitals will become high-intensity nursing homes intensive care units and delivery centres for neurosurgery, cardiac and cancer surgery which would have been priced out of the private sector with consultants on 'casual' contracts to provide a service rather than employees. This would represent a return to the voluntary hospital and visiting staff model from the 19th century.

The possible unintended consequence is that this proposal may work to the advantage of the private system at the expense of the public!

Yours sincerely

David O'Keeffe

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