Submission on the consultation on Private Practice in Public Hospitals
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Introduction

Thank you for having this much needed consultation, which can help address the crippling costs and worsening outputs of the national health service. I hope that this consultation is framed around the target of introducing slaintecare to Ireland's public acute hospitals.

All of the following observations and suggestion below benefit from the use of RAG ratings, process maps and costing tables.

Eligibility, access and equity

The current system of qualification, regulation, employment and investment by doctors in their vocation is opaque to the public and unrewarding to the doctors. Cultural change must be displayed from the top if the bottom is to believe that change is meaningful. *Public hospitals must transition from consultants to specialists*. Three grades of specialism allows for career progression and the expansion of employment in healthcare without increasing spending. A percentage of those that enter into a speciality, should be given a posting every recruitment cycle.

The accessors for the need for appointments should be by a state body and not by hospitals. The accessors should, in the majority, be from outside of Ireland.

Limiting the number of years which one operates at the various specialists grades 1, 2 or 3 can only be for a set number of years to allow a flow of doctors. After this point existing specialists can transfer to the private system, become researchers, teachers, academics or managers. The new influx of specialists will have upto date training and have a path of progression.

At the highest specialisation level doctors should only be practicing to grow expertise and test research in the field. They should not be managing or teaching. Those that have past this stage should be enabling the field. This is done by research, teaching or private practice with the facility to return periodicly to practice so as to maintain skills or temporarily increase capacity.

Current and future funding arrangements

The costs incured by doctors and the costs incurred in using doctors have to be compared on a ratio to show the negative or inefficient cost of using private doctors in a public system.

The costs incurred by the doctors public, private and mixed must be transparently graphed and tabled. This should show the cost of living, the source of funding for them in comparison to the cost of employing them as it applies to each member of the public:

- by tax types and rates
- patients and non-patients
- Those that pay privately
- savings to companies – mix systems slow down the return to work time of public patients

On the cost to the doctor the cost of living needs to compare student debt, state financing and every detail of achieving the like for like quality of life in Australia and Ireland. The funding of tuition is key. The full cost, as per international students, should be applied and shown to students entering into education in Autumn 2018.

Students can pay upfront the full cost as would be charged to an international student or deferred into their state bank account. If the student pays back the costs via staying in public acute hospitals then the loan is held by a state back at 0% interest and part of the renumeration for a public doctor is accelerated loan pay off.

If the qualified doctor leaves the Irish public system, then the debt it attached to a visa card in the name of the graduate and anchored to that doctor where ever they travel. Their new employer may pay off the loan or they may get a separate loan or a gift from their parents.

Finally the cost to patients of using private versus public systems needs to be clearly and repeatedly displayed. The sources of payment and the comparable metrics of patient outcomes should be visible. The objective is to build the recognition of the benefit to the public and reputation of the doctors within the public service, thus aiding retention and recruitment.

Legislative and legal issues

Law surrounding medical language around doctors needs to be changed, jargon and ritual must be killed for progress to commence. Phrases like 'senior house officer' is an archaic term from the 1800's, it is designed to confuse and intimidate patient, while placing the doctor in a state of unwarranted granduer. Provide modern, accessible, terminology for the types and levels of doctors that operate in public acute hospitals. Let the wrath, fe

Examinations for graduating doctors should be a akin to the leaving certificate. Doctors should never be tested by their own teachers. Objective merit base qualification is key.

Operational matters including specialist services

Visibility of systems, structures and patients through the services is required. Systems, structures and KPI should be visible to analysts, academics, journalists, the public and most importantly patients. Once patients see the flows of money and system complexity between public and private there should be a universal design to simplify and separate this intertwined system.

The maintenance of skills (public and private) should run through the Medical Authority and frequent & decrete mandated conferences for all doctors to compare and contrast the procedures, processes and developments in their specialties.

Transparency and comparison should also apply to operational matters. Publicly visible, concisely called out services and a transparent map of the flow of patients through the operational systems is required. This shoudl be communicated so that first year medical student should know as much about operational design maps as surgery checklists.

Recruitment and retention of personnel; and

Retention of personnel must start with analysing the underlying causes of those who left. Australian university hospitals with high levels of Irish qualified doctors should be surveyed by Irish university psychology departments. The addage that people join for the job snd leave due to the management is core to retention. This is not just line managers and organisation managers, but also system management. This ends with the Minister for Health, a Minister who must lead in the culture shift and not worry about seeking votes from vested interest groups.

Recruitment analysis needs to start with those that are recently recruited in Ireland and compare to systems from other countries. Access to facilities, continuous eduction, career progression, quality of life and recognition are key. Quality of life needs to consider the obstacles, contraints and dependencies and not the pay level. Where the market works then it should be used, but it the market is an obstacle or constraint e.g. housing, commute time, quality of childcare/education, then joined up thinking across government departments must be considered using objective metrics for success and not GDP. An an example, if large profit drive technology companies build living campuses for their employees to pick up where the market place fails then the Department of Health needs to think outside the mental constraints of traditional limited thinking.

CAO applicants must be shown the path to becoming a specialist and the cost of leaving the system that is paying for the majority of their education. Attention should also be drawn to the failure rate of private medical practice and the number of drop outs from the profession, by both those practicing privately and publicly.

Practical approaches to removing private practice from public hospitals including timeframe and phasing.

GDPR and BREXIT are excellent opportunities to place timeframes on changes in the separation of public and private doctors in acute public hospitals. GDPR compliance would naturally be more complex, especially if a patient is staying with the same doctor as s/he transfers from public to private or vice versa.

Importantly the responsibility must be for the personal signature of the doctor on the compliance form with legal penalties spelled out beneath the signature. However GDPR compliance should be simple, clear and ease for those that are either exclusively public or private doctors e.g. one signture annually rather than one signature per patient. Risk and cost must be visible, unavoidable and repetitive to those spanning the public-private mix.

From autumn 2018 medical students and the public must be educated on how the current system arose and the traditions that should no longer be tolerated in the current problematic public-private situation. If context of problem can be seen and then context of the solution can be made more clear. The objective of this is to remove the rhetoric and opinion around the debate that will follow this consultation. Much has already been written on this, it only needs to be summarised in the Irish context.

Co-location or private hospitals providing public services are the major problem. Either they must become fully private or fully public within slaintecare in a decade or the board will be subject to onerous transparency and expensive compliance costs. This should be similar to EU fines on CO2 targets. It is the culture of individual decision makers that needs to be targeted, along with constantly highlighting the effects of their failures – e.g. Mr X head of Y hospital is responsible for 30,000 trolley days and the suffering on public patients in a mixed public private hospital.

Conclusion

Think of specialists in public acute hospitals as provisional squad members seeking access to the national rugby team. Merit wins out, quad members can only operate a peak for a limited time and a clear route exists to progress from one level to the next. This is all within the scape of rewarding for loyalty and national pride.

Remember that universal understanding through transparency is key. There is a need to know :

- organisational structures & their interplay
- the flow of funding & expense
- the system of qualification, recruitment & progression.
- These must be understood for objective external critiquing so as to improve the outputs and

outcomes for the public and the nation.

If one cannot map it and mark it then one should never make it an option.

Regards,

Mark Keogh