IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Irish Medical Organisation Submission to the Independent Review Group on

Private Practice in Public Hospitals

February 2018

Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2
Tel: (01) 6767 273
Fax: (01) 6612 758
E-mail: codowd@imo.ie
Website: www.imo.ie

The Irish Medical Organisation (IMO), welcomes this opportunity to make a submission to the review of the proposal for the removal of private healthcare from public hospital facilities contained within the 'Sláintecare' Report, published by the Houses of the Oireachtas Committee on the Future of Healthcare in May 2017.[1]

The IMO is the trade union and professional representative body for all doctors in Ireland, and has been a consistent advocate for healthcare investment and reform in this country. The IMO has consistently argued, through its submissions to public consultations, budget submissions to government, and in its appearances before Oireachtas Committees and other public fora, that major investment is required in our public health services to increase their capacity. Ireland is facing unprecedented demographic changes, and growing complexity in medical and surgical treatments, all of which present challenges our public health system, which has suffered from many years of severe underfunding.

In its submission to the Houses of Oireachtas Committee on the Future of Healthcare, the IMO explicitly called for increased resources to be provided to the public health system, to enhance capacity in order to provide appropriate care in a timely manner to all patients.

Regrettably, however, a proposed solution to the present capacity crisis contained in the Sláintecare Report, i.e. to remove the provision of private healthcare from public hospital facilities, may not achieve its stated aim. Little to no evidence was provided by the Committee to demonstrate that this proposal would generate additional capacity within the public hospital system. Instead, the IMO fears that this recommendation would not only fail to produce any meaningful increase in public hospital capacity, but would also deprive the public system of a much needed source of revenue. In addition, the IMO is concerned that the proposal, if enacted, would create a further, avoidable, barrier to Consultant recruitment and retention in Ireland.

The IMO is concerned that the recommendation to remove private care from public hospitals rests on flawed assumptions about the private and public health systems. This recommendation, while aspirational, will ultimately prove deeply problematic, and ultimately harmful in its implementation. Instead, the IMO recommends that the costs that would inevitably arise in segregating the two systems be used to provide new public beds and the attendant staff to genuinely bolster the capacity of the public hospital system.

A Recommendation Based on Flawed Assumptions

The proposed removal of private care from public hospitals outlined in the Sláintecare Report reflected a belief that the removal of private care from the public system would, create additional public health service capacity. This belief is set out by the Committee in the following excerpt from the Sláintecare Report.

> "The Committee supports the principle of separating public and private care in public hospitals. Providing timely access to public hospital care will be achieved by the expansion of public hospital care, guaranteeing and delivering specific waiting time guarantees, and re-orientating the system so that the vast majority of care is delivered and accessible in primary and social care settings as is clinically appropriate, and by addressing under-staffing across the health system. In addition, the phased removal of private care from public hospitals alongside these measures will lead to an expansion of the public system's ability to provide care to public patients, thereby

[1] Houses of the Oireachtas Committee on the Future of Healthcare, Sláintecare Report, May 2017, p. 68.

> providing universal access to public hospital care in a reasonable period of time (The time guarantees for access to public hospital care are specified in Section 3, and, under this plan, will be underpinned by legislation.)
>
> Current policy which removed the 20% limit of private work in public hospitals combined with the current practice of setting private patient income targets for public hospitals are perverse incentives. These should be removed by phasing out private work from public hospitals between year 2 and 6 of this plan and replacing private patient income currently received by public hospitals over the same period. Based on current figures, this is costed at €649m.
>
> Over this time, this income will be replaced by activity based funding for public patients, as more public patients will be treated as private patient numbers decrease. The Committee recognises and recommends that existing contracts may change through negotiation and the need for enhanced public only contracts for new recruits. Central to achieving this is ensuring the Irish public health system is a place where staff feel valued and in which they want to work."[2]

The IMO maintains that the belief that removing private care from public hospitals or facilities will generate greater public healthcare capacity rests on a number of assumptions, for which little to no evidence was provided by the Committee. The IMO also contends that, in making this recommendation, the Committee did not adequately consider the full range of consequences of the complete removal of private care from public hospitals.

Assumption 1: Patients with Private Health Insurance Will No Longer Seek Care in the Public Hospital System

Approximately 46% of the Irish population holds some form of private health insurance,[3] thus potentially enabling such patients to obtain private medical care. While many patients elect to purchase private health insurance, this act does not disentitle those patients from obtaining healthcare within the public system, as they are ordinarily resident in Ireland. For patients who hold a medical card this provides an entitlement to hospital care which is free at the point of access, and for non-medical card patients co-payments of €100 for accessing hospital emergency care without a GP referral and €80 a day for in-patient services up to a maximum of €800 a year.

It is highly unlikely that private patients admitted on an emergency or maternity basis would, or could, redirect their care out of the public hospital system. Indeed, a recent review of changes in the public and private composition of hospital discharges revealed that measures introduced by the then Minister for Health, in 2014 to enable public hospitals to charge private health insurers for beds occupied by their customers, in essence a pure revenue raising measure, regardless of whether that bed was designated as public or private did not affect the proportion of private and public patients within the system, nor the proportions attending emergency departments.[4] As set out in the report:

> "Public patients accounted for between 83% and 84% of total public hospital discharges over the 2012 to 2016 period. Within day case discharges, public patients accounted for 86% of all discharges in 2012 and this had decreased to 85% in 2016. For emergency inpatient discharges, public patients accounted for 80% of public hospital

[2] Houses of the Oireachtas Committee on the Future of Healthcare, Sláintecare Report, May 2017, p. 68.
[3] The Health Insurance Authority, 2016 Annual Reports and Accounts, Dublin, 2017, p. 18.
[4] Department of Health, Trends in Public / Private Patient Activity in Public Acute Hospitals, Statistics and Analytics Unit, pp. 14-15.

> discharges in 2012, and this increased to 81% in 2016. Within elective inpatient discharges, public patients accounted for 73% of total discharges in 2012 – the same level as in 2016. For maternity related discharges, public patients accounted for 83% of total discharges in 2012 and this increased to 84% in 2016."[5]

Evidently, therefore, the potential for their health insurer to be charged for the care received, in spite of the designation of the bed in which that care is received, did not dissuade holders of private health insurance from attending at public hospitals. It must also be recognised that the extent of services available in the private sector does not equate to that which is available in the public sector, such as the absence of twenty-four hour emergency departments at private hospitals. This is , likely to result in the continued attendance of many patients who hold private health insurance in the public hospital system, even if the proposal for the removal of private care from public hospitals is realised.

This calls into serious question the additional public bed capacity that could be generated by removing private care from public hospitals. The notion that removing private care from public hospitals would generate additional capacity within the public system is predicated on the assumption that a significant number of patients who hold private health insurance would no longer seek healthcare in the public hospital system. No evidence has been produced to indicate that patients who currently obtain private care within the public hospital system would waive their rights as citizens and seek to obtain their care elsewhere, subsequent to the removal of the option of receiving private care at that location.

Therefore, before recommending the removal of private care from public facilities, it would have been advisable to conduct an examination of whether patient behaviour, in terms of where they choose to obtain care, would be affected by the removal of private care from public hospitals. Making assumptions about patient behaviour in such circumstances may result in inflated expectations about the amount of capacity that would be generated should patients no longer be seen on a private basis in public facilities.

Similarly, little information was provided as part of the report as to the amount of bed capacity in public hospitals occupied through the provision of private care. A 2008 analysis of bed capacity in Ireland determined that, at that time, there were 11,660 public patient beds, and 2,461 private patient beds in public hospitals.[6] A later assessment, from 2012, showed that, of the 12,604 beds within the public hospital system, 2,502 were designated for private use.[7] A more recent assessment from 2016 showed that these figures had remained largely stable.[8] Overall, throughout 2016, private patients accounted for just 16.4% of all discharges in public hospitals.[9]

All suggestions are that bed occupancy within the public hospital system, regardless of designation, is very high. Bed occupancy rates published in 2016 found that bed occupancy in Ireland had risen to 97%, and sat an average of 104% in Model 4 hospitals.[10] No evidence has been presented that the

---

[5] Ibid.

[6] PA Consulting Group, *Acute Hospital Bed Capacity Review: A Preferred Health System in Ireland to 2020*, Dublin, 2008, p. 6.

[7] Department of Health, Public Hospital Bed Numbers, available at: http://health.gov.ie/publications-research/statistics/statistics-by-topic/public-hospital-bed-numbers/.

[8] Department of Health, Trends in Public / Private Patient Activity in Public Acute Hospitals, Statistics and Analytics Unit, p. 3.

[9] Health Service Executive, *Activity in Acute Public Hospitals in Ireland: 2016 Annual Report*, Healthcare Pricing Office, September 2017, p. 12.

[10] Department of Health, *Interim Report and Recommendations by the Taskforce on Staffing and Skill Mix for*

designation of beds within the public hospital system, to the extent that these designations still apply, causes a limitation in the overall capacity of public hospitals, or a reduction in the number of patients treated through the public hospital system. Therefore, it is far from certain that the removal of private care from public hospitals could generate additional overall bed capacity within public hospitals.

Assumption 2: The Private Hospital System Has, or Can Supply, Additional Capacity to Treat Private Patients Currently Treated within the Public Hospital System

The only manner by which the removal of private care from the public hospital system could generate additional health services capacity would be in instances where patients who hold private health insurance would no longer seek care in the public hospital system. No evidence has been provided, either by the Oireachtas Committee on the Future of Healthcare, or by any other public body subsequent to the publication of the Sláintecare Report, that capacity exists within the private hospital system to treat patients who currently obtain private care within public hospitals.

A 2008 study suggested that there were 1,926 hospital beds within the private hospital system at that time.[11] A recent submission to the Oireachtas Committee on the Future of Health by the Private Hospitals Association, a representative body for nineteen private hospitals in Ireland, stated that approximately 2,500 hospital beds exist within the private hospital system.[12] No figures appear to exist on the level of bed occupancy within the private hospital system. However the most reasonable assumption would be that present bed stock is demand-driven and that it is unlikely that large numbers of unoccupied beds sit continuously available within private hospitals. Neither is there any evidence to suggest that physical capacity and capital exists within the private hospital system to dramatically increase the number of patients treated within this system.

The likelihood is that, while a small amount of additional capacity may exist within the private hospital system, it is improbable that this system holds the capacity to treat the cohort of patients currently obtaining private care within the public hospital system. This is particularly so given the proportion of private care within public hospitals generated through emergency and maternity admissions, which may not be readily, or comprehensively, accommodated within private facilities.

Concerns about the Removal of Private Care from Public Hospitals

As demonstrated, the suggestion that the removal of private care from public hospitals will generate additional public healthcare capacity rests on two assumptions which have little evidential basis. Paradoxically, there is evidence that the removal of private care from public hospitals may reduce overall healthcare capacity in Ireland, and weaken this country's ability to recruit and retain medical staff.

Hospital Financing

The Sláintecare Report identified that, based on 2016 figures, the withdrawal of private care from public hospitals would create a significant annual funding shortfall within the public hospital system of €649 million.[13] On a ten year basis, this amounts to a nominal budgetary reduction of approximately €6.5 billion. The report also recommended that the budgetary shortfall created by the

---

Nursing, Dublin, February 2016, p. 27.

[11] PA Consulting Group, Acute Hospital Bed Capacity Review: A Preferred Health System in Ireland to 2020, Dublin, 2008, p. 6.

[12] Private Hospitals Association, Submission to the Oireachtas Committee on Healthcare, Dublin, August 2016, p. 3.

[13] Houses of the Oireachtas Committee on the Future of Healthcare, Sláintecare Report, May 2017, p. 124.

removal of this private income be made up through the levying of additional taxation. This would equate to approximately €294 annually in additional taxation per employed person in Ireland, or €135 per person living in Ireland.[14]

Given the historical and severe underfunding of the Irish public health service, an underfunding that persists to this day, it is difficult to imagine that this funding shortfall, a shortfall of choice, will be quickly or easily addressed. The likely consequence of the removal of private care from public hospitals is to further reduce the funding available to the public health budget.

Furthermore, the provision of private care within public facilitates the integration of private expenditure on health, most often through private health insurance, into the public system. It must be recognised that this healthcare expenditure will occur, regardless of whether the care takes place within public or private hospitals. By removing private care from public facilities, this portion of expenditure on healthcare will either take place exclusively in private settings, or fall due to the State owing to the removal of private funding sources for public hospitals.

The financial strain under which public hospitals consistently operate, and their constant need for additional funding to provide necessary services, has led to pressure being placed on a number of Consultant staff to generate additional private income for their public hospitals. In a survey of Consultant members recently conducted by the IMO, Consultants were asked a number of questions about public and private practice. Of those Consultants who hold contracts of employment that allow them to engage in some private work, 34%, or around one-third, stated that they been encouraged by hospital management to generate additional income for the hospital from private sources, or they were aware of a colleague who had been so encouraged.[15]

Consultant Working Hours

The vast majority of medical Consultants employed in Ireland, some 83%, are employed on contracts that permit them to engage in private practice once their contractual hours of work within the public system have been discharged.[16] This arrangement can allow for Consultants to work above their contractual public hours, thus raising the overall number of hours worked in the provision of healthcare in Ireland. A recent survey on Consultants conducted by the IMO revealed that approximately 85% report working in excess of forty hours a week, while around 19% report working in excess of sixty hours a week.[17] This indicates that the vast majority of Consultants in Ireland are providing a considerable volume of working hours, above their contracted and discharged public hours, in the provision of patient care.

Additionally, 68.6% of Consultants who hold contracts that permit some private practice do not have access to private facilities that would enable them to treat patients outside of the public system. Given that many Consultants provide a large number of working hours in excess of those required by their public contracts, it must be considered that the inability to treat private patients within the public hospital system may mean an overall reduction in total Consultant working hours. This may arise due to a greater proportion of Consultants working only the hours provided for in their public contracts, having been prevented from providing additional patient care hours through private practice, and in the absence of alternative facilities.

[14] Calculated on the basis of the Central Statistics Office's Labour Force Survey: Q3 2017, which showed there to be 2,206,800 people working in Ireland; and the Population and Migration Estimates: April 2017, which showed there to be 4,792,500 people living in Ireland.
[15] Irish Medical Organisation, *Consultant Survey on Private Practice in Ireland*, January 2018.
[16] Health Service Executive, business correspondence, November 2017.
[17] Irish Medical Organisation, *Consultant Quarterly Survey*, October 2017.

Consultant Staffing

Ireland already possess one of the lowest numbers of medical specialists, or Consultants, *per capita* in the developed world. Statistics compiled by the Organisation for Economic Co-operation and Development (OECD) show that Ireland has the fewest medical specialists per capita and the third fewest surgical specialists *per capita* of any of the twenty-two surveyed European Union states.[18] These were measured at 0.59 medical specialists per 1,000 population in Ireland compared to an EU average of 1.05 per 1,000 population; and 0.46 surgical specialists per 1,000 population in Ireland compared to an EU average of 0.71.[19]

The Sláintecare Report "recommends that existing contracts may change through negotiation and the need for enhanced public only contracts for new recruits."[20] Notwithstanding the long running dispute centred on the failure of the State to implement the last negotiated contract, this is problematical. Indeed, given the unavailability of separate private facilities to most Consultants, it is difficult to envisage how a complete segregation of the private and public healthcare systems could be achieved without a corresponding segregation of the private and public Consultant workforces. The present system facilitates Consultants in performing both private and public work. Once this accommodation is removed, many Consultants may have to choose whether to operate under wholly private or wholly public contracts. The prospect of spreading our existing low level of Consultant staffing even more thinly, by forcing a hard private and public separation of the Consultant workforce, may further reduce the already low level of Consultant staffing within the public health service. The perception that may be created amongst patients and the general public, and the effects of such a perception, by a hard separation of the public and private Consultant workforces should be borne in mind.

In a recent IMO survey, Consultants were asked would they consider leaving the public health system if they were unable to continue to treat private patients in a public facility. The majority, 56%, said that they would consider leaving the public health system if such segregation was to be enforced arose.[21]

It is also worth noting that the introduction of the Type A Consultant contract in 2008 was envisaged to create a large number of Consultants employed only within the public system, and the IMO notes that the Slaintecare report envisages the creation of a further 593 Type A public only Consultant posts, albeit by year four. However, owing to the severe recruitment difficulties experienced by hospitals in offering these contracts, Type A contracts very much constitute a minority of Consultant posts within the public health system, amounting to only around 17% of all posts, and fewer than 10% in the acute sector.[22] Typically, public only contracts have proven to be less attractive to applicants than contracts that allow for a measure of private practice. Therefore, and based on measured experience, an exclusively public hospital system may develop recruitment and retention difficulties more severe than the problems currently being experienced. The agreement of a new public-only contract, should that even be possible, may serve to create greater discrepancies than already exist between new entrants and current staff, with such discrepancies already acting as a significant barrier to recruitment and retention.

---

[18] Organisation for Economic Co-operation and Development, *OECD Health Statistics 2017*, Health Care Resources, physicians by categories, available at: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT.

[19] Ibid.

[20] Houses of the Oireachtas Committee on the Future of Healthcare, *Sláintecare Report*, May 2017, p. 68.

[21] Irish Medical Organisation, IMO Consultant Survey on Private Practice, January 2018.

[22] Health Service Executive, business correspondence, November 2017.

Consultant Recruitment and Retention

A factor contributing to the low number of doctors working in Ireland are unattractive working conditions, and levels of remuneration that both drive emigration of doctors from Ireland, and inhibit the return of doctors who have already emigrated. This affects all levels of medical practitioner. A Medical Workforce Analysis, published by the Department of Public Expenditure and Reform from 2015 highlighted that 87% of medical students are either intending to emigrate or contemplating it,[23] while a Medical Council examination of the retention intentions of Irish trainee doctors revealed that just 58% of trainees see themselves practising in Ireland for the foreseeable future.[24]

Recruitment and retention problems severely affect the Consultant workforce, as demonstrated below, and indications are that a complete removal of private practice from taking place within the public hospital system may further hamper Consultant recruitment and retention. At a time when large numbers of NCHDs, including specialist registrars who are close to specialist qualification, are emigrating, this proposal will likely lessen the Irish health system's attractiveness to new specialists.

Consultant Recruitment

Consultant recruitment has proved highly challenging in Ireland. Figures obtained by the IMO from the Public Appointments Service (PAS) has revealed that, of the 84 Consultant posts that were advertised and closed in 2016 by the PAS, one-quarter (22) received just one application, while another quarter (21) received just two applications. One-in-ten (8) advertisements were closed without a single application being lodged for the position.[25] The PAS was unable to identify a suitable applicant for 22 of these 84 posts.[26] These statistics demonstrate that 60% of advertisements for Consultant posts in the Irish health service last year attracted two applications or fewer. In a highly competitive global market, Consultant posts in the Irish public health system simply do not attract the number of applicant that one might suppose.

Recruitment efforts in 2017 have proved no better, and of the 38 Consultant positions currently being advertised by the PAS, 16 have been open for over twelve months. Additionally, 128 Consultant positions are currently being occupied by practitioners who are not on the specialist register.[27] It is a condition of the Consultant contract that persons occupying these roles must have achieved specialist qualification and be listed on the specialist register of the Medical Council.

While the exact level of Consultant vacancies within the Irish health system is unclear, it is generally accepted that up to 500 such posts are either vacant, or are filled on a temporary basis.[28]

These figures should greatly concern health policy makers as health service management often has little choice in the personnel it employs, frequently having to appoint qualified Consultants from extremely small pools of applicants. In some cases the high number of vacancies has led to the health service appointing practitioners who have not achieved specialist qualification to Consultant roles. Appointing practitioners who have not achieve specialist qualification to Consultant positions may create patient safety concerns and clinical risks.

---

[23] T. Campbell, *Medical Workforce Analysis: Ireland and the European Union compared*, Dublin, Department of Public Expenditure and Reform, 2016, p. 1.
[24] Medical Council, *Your Training Counts: Spotlight on Trainee Career and Retention Intentions*, Dublin, 2016, p. 6.
[25] Ibid.
[26] S. Mitchell, business correspondence, 10 November 2017.
[27] L. O'Reilly, Dáil Éireann Debates, Parliamentary Question No. 210, 29 June 2017.
[28] C. Burke and R. Bruton, Seanad Éireann Debates, 22 June 2017.

Consultant Retention

Staff turnover figures collected by the HSE for 2016 show that 46% of those who left did so due to the expiration of their contract but that 39% who left resigned their.[29] Just 13% of those who left Consultant posts did so due to retirement. This means that only 36 of the 279 Consultant posts that were vacated in 2016 could be said to be as a result of retirement. The overall turnover rate for Consultants in the HSE was 8.9% last year, while the corresponding figure for NHS England sat at just 6.1%.[30] Consultant emigration from Ireland is poorly studied, however these statistics shed light on the considerable problems that exist for Consultant retention in the HSE, and show that leaver rates are substantially higher for this class of doctor than in the UK. Of the replacement Consultant posts that have become available within the HSE since 2015, 73 have arisen from Consultant resignations.[31]

The outcomes of the IMO Consultant Survey on Recruitment and Retention Issues give some indication of the issues driving Consultants away from positions within the Irish public health service.

The survey revealed that 27% of Consultants indicated that they were considering taking up a post abroad in the foreseeable future. The four most frequently cited factors leading them to consider a move were:

- better workplace atmosphere, culture, and supports elsewhere (76.7%);
- higher levels of remuneration elsewhere (73.3%);
- higher doctor staffing levels (70%); and
- better opportunities to avail of education, training and continuous professional development elsewhere (60%).[32]

Separation of Private and Public Practice as a Driver of Emigration

A survey of Consultants based in Ireland demonstrated a number of findings, based on the responses of Consultants whose contracts entitle them to carry out some private work:

- 81.3% believe that once a Consultant has discharged his or her public commitment, he or she should be permitted to treat patients privately in public facilities.
- As aforementioned, 56% state that, were they unable to continue to treat private patients in a public facility, they would consider leaving the public health system.
- 58.2% believe that removing private patients and private practice from public hospitals will worsen the overall level of care given to patients.
- 90.1% feel that the proposal to prevent private practice from taking place in public hospitals will make the current difficulties in recruiting Consultants worse.[33]

A similarly pessimistic view of the effect the removal of the provision for private practice will have on Consultant recruitment and retention was expressed by survey responses of Irish Consultants working abroad. Of this group:

- 69.2% state that an inability to treat private patients in public facilities would influence their decision on whether to work in the Irish public health system in the future.

[29] Health Service Executive, *Staff Turnover Report 2016*, Dublin, 2016, p. 7.
[30] NHS Digital, *NHS Hospital & Community Health Service (HCHS) workforce statistics*, July 2017.
[31] Figures derived from Consultant Appointments Advisory Committee data.
[32] Irish Medical Organisation, *IMO Consultant Survey on Recruitment and Retention Issues*, November 2017.
[33] Irish Medical Organisation, *IMO Consultant Survey on Private Practice in Ireland*, January 2018.

- 76.9% feel that the proposal to prevent private practice from taking place in public hospitals will make the current difficulties in recruiting Consultants worse.[34]

These figures when taken together show that the recruitment and retention problems affecting the Consultant workforce in Ireland are only likely the be exacerbated by the removal of private practice from public hospitals, which would, on the whole, render the Irish public hospital system a less attractive workplace.

Conclusion

The IMO asks the Independent Review Group to give full consideration to the concerns it has raised within this submission. Ireland's population is both growing and ageing, two factors that demand increased capacity and resourcing within the public health system. The IMO is confident that the available evidence suggests the Slaintecare proposal for the removal of private healthcare from public hospital facilities is unlikely to generate meaningful additional public healthcare capacity. Additionally, it is a proposal that carries numerous risks including the potential to deprive the public system of a much needed source of revenue, running into the billions of Euro, as well as creating a further barrier to Consultant recruitment and retention in Ireland.

Insufficient consideration has also been given to new contracts or working arrangements that may be required to operate such a system. Currently, over ninety percent of Consultants in the acute sector have a contractual entitlement to treat patients privately, with a clear majority of those entitled to do so in public facilities. To remove this entitlement, wholesale, will require the negotiation of a new Consultant contract, and cognizance must also be taken of the rights of those Consultants who may choose to retain their current contract. It is also vital to remember the credibility chasm in the background; due to the non-implementation of the agreed salary rates associated with the 2008 contract, those who signed up for the public only Type A option suffered the greatest losses.

Similarly, the effects of the elimination of private care from public hospitals in creating geographic discrepancies in access to care appear not to have been considered by the Committee in making this recommendation. Nor does the Committee appear to have engaged in any meaningful consideration of whether the creation of an exclusively publicly healthcare system, similar to that of the NHS in the United Kingdom, which at present is experiencing considerable financing and service challenges, is immediately replicable within a country of Ireland's size, demographic make-up, population distribution, and health profile. Such investigations, and resulting evidence of impact on service availability, delivery, and cost must sensibly precede any significant changes to the nature of services provided in Irish public hospitals.

The IMO reasserts its view that the most effective way to improve public hospital capacity is to expand existing bed numbers and staffing, which can reduce bed occupancy below 85% to ensure patient safety and provide for seasonal increases in demand,[35] and also provide for more timely care. Simply shifting the designation of hospital beds from private to public will not increase bed numbers in Ireland, nor reduce bed occupancy to safe levels. The IMO calls on the Independent Review Group

[34] Irish Medical Organisation, *IMO Overseas Consultant Survey on Private Practice in Ireland*, January 2018.

[35] A. Bagust, M. Place, and J.W. Posnett, 'Dynamics of bed use in accommodating emergency admissions: stochastic simulation model', *British Medical Journal*, Vol 319, July 1999, pp. 155–158; R. Jones, 'Hospital bed occupancy demystified', *British Journal of Healthcare Management*, April 2011, dx.doi.org/10.12968/bjhc.2011.17.6.242; F. Madsen, S. Ladelund, and A. Linneberg, 'High Levels Of Bed Occupancy Associated With Increased Inpatient And Thirty-Day Hospital Mortality In Denmark', *Health Affairs*, Vol. 33, No. 7, July 2014, pp. 1236-1244.

to recognise this fact, and to instead recommend the implementation of an immediate and effective plan to expand public bed numbers to meet current healthcare demand in keeping with the advice given following the capacity review commissioned by the Minister for Health.