Proposed elimination of private medicine from public hospitals.

This opinion is offered in response to public advertisement following the Slaintecare Report, seeking views regarding the above. I write from the perspective of a consultant surgeon/professor who worked his full career of 35 years at consultant level in a public hospital, and only in a public hospital, doing predominantly public work, but some private work on site. I have worked in Ireland, Great Britain, the United States and now in Asia.

Consultant Contracts

The present system of consultant contracts in iniquitous and is neither managed nor manageable. It has been allowed to drift into a situation in which most consultants in public hospitals are allowed to practice off site in private institutions with a derisory salary differential from those who work fulltime on the public site. There should be a large salary, pension and benefit differential between the two in order to encourage their retention on the public site. The ability to escape to practice in a more comfortable professional ambience in a private institution, or a private appendage to a public institution where the boundaries are blurred, when resources are constrained on the public side, unfortunately allows some to advocate less and fight less for the public one, where they remain permanent and pensionable. This is not universally the case throughout the country but is an important factor in powerful opinion forming centres. The ultimate absurdity is when, for example a surgeon, often denied access to an operating theatre in the public hospital, is paid to operate on National Treatment Purchase Fund patients in a private institution: double jeopardy for the taxpayer.

Social Cohesion

It is desirable that all strata of society should mingle in publicly funded medical institutions. For this to happen the better off must feel confident with regard to access and scientific standards. While the middle classes generally appear happy with scientific standards once they get into the system, they find access deplorable and 50% take out private health insurance. Clearly it would be undemocratic, as is proposed, to prevent this 50% from exercising their private

prerogative in public institutions which, in any case, their taxes sustain. This proposal will, regardless of good intentions, result in further separation of patients according to their means.

Recruitment

Page 13 of the Slaintecare Report admirably states that
*"Recruitment and retention of staff is critical".*
However consultant posts in public hospitals, previously avidly sought after, often now, in a country producing doctors at public expense, have no indigenous applicants. The elimination of private medicine from these institutions will make this situation worse. The institutions will become socially unbalanced. The Irish public have made it clear enough that they regard medicine as a branded product and not a commodity (the word used on page 57 of the report). Indeed it is discouraging that consultants are already quitting the public side for the private and some are re-emigrating. Furthermore many of our graduates, who undertake arduous postgraduate training programmes abroad in the best medical institutions of the world, will not return and posts will be filled by those of lesser accomplishment and suitability who have not exposed themselves to such rigours. This, ultimately, will impact on the patient and on standards.

Public hospital consultants are remunerated on a standard scale regardless of how much work they do. Indolence and industry are equally rewarded. Ways should be found to relate reward to productivity. In the United States salaries are struck on the basis of what a senior doctor brings to the institution in terms of clinical work, research, administration and prestige. In Britain`s National Health Service, Merit Awards likewise provide incentive and can as much as double salary and pension. In Ireland private practice substitutes for such benefits. If such differential benefits were introduced the imperative for private practice would diminish and productivity would improve.

Morale

*"The committee received extensive evidence from demotivated staff".*

This frank statement from page 22 of the report is welcome. The intangible asset of morale is not valued. Hospital staff should feel that they are working in

an enterprise with a product for a market as private hospitals do. Until the resource problem is dealt with morale will always be crushed by the inability of highly trained staff to discharge their functions. The feeling that they are at least generating some revenue apart from government funding is good for personal and institutional morale. The feeling that comes from looking after all echelons of society is also good for morale. If private medicine is driven out, as is proposed, these positive factors will evaporate. Until there are profound funding and organisational changes, and the latter are more important, the danger of public institutions becoming stigmatised as places to which well off people do not go re- emerges: then we are back to the place from which we have struggled for long to emerge.

Funding

We hear much in Ireland of the need to "widen the tax base". Yet the funding base of public hospitals will be narrowed if the present private income of Euro 649 million per annum is eliminated as proposed. The promise that this will be replaced from general taxation is not convincing to those who have struggled in public hospitals during several boom-bust cycles. Sacrificing this income, in a nation as indebted as we are, would amount to self harm. Public hospitals, by catering for all levels of society including private health insurance subscribers, should harness income from these latter to the general good. Health planners would do well to remember what the abolition of university fees, with the promise that they would be replaced from central funds, has done for university ratings.

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