Opening Statement by Dr. Brian Turner

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Committee on the Future of Healthcare, 25th January 2017

I would like to begin by sincerely thanking the Committee for the invitation to address you here today. It is a great honour and a privilege to be asked to contribute to the very important work that the Committee is undertaking and I hope that my appearance here today will be of some assistance in this regard.

I think it is worth acknowledging that, despite its flaws, the Irish health system also has its good points, and these should not be forgotten. Patients are generally happy with the treatment that they receive in hospitals, although access can be a problem. Most people can receive a same-day or next-day appointment with a GP, something that is not always the case in other countries. Life expectancy and self-assessed health status are both above average in Ireland. Our health system is getting some things right and those areas that are working well need to be built upon, while addressing the shortcomings in other areas.

When examining the workings of a health system, economists sometimes use what is known as the healthcare triangle, which is illustrated in Figure 1. Unlike most goods and services, healthcare often – though not always – involves a third-party purchaser, which pools contributions and purchases care on behalf of contributors. Citizens provide funding to the third-party purchasers, which allocate funds to providers, who deliver care to those who need it. Using third-party purchasers involves an element of social solidarity, as a large group of people pay into the pool, while not all will require treatment. This system thereby reduces the risk that would be faced by citizens if they were obliged to pay the full cost of all of their care themselves.

In Ireland, it could be argued that we have two healthcare triangles, operating alongside each other. In the public health system, all citizens pay taxation, which is pooled by the Government and allocated, via the HSE, to providers, who deliver care to public patients. Simultaneously, we have a private system where nearly half of the population pays premiums to private health insurers, which pool those funds and allocate them to providers, who deliver care to private patients. There is also a system of direct, out-of-pocket payments, which are paid directly by some citizens to providers for care – examples would include payments to GPs by patients who do not hold medical cards or GP Visit
cards, and payments to pharmacies for prescription medication (up to the Drug Payment Scheme threshold) by patients who do not hold medical cards.

**Figure 1: The Healthcare Triangle**

One source of difficulty in the Irish system stems from the fact that public and private patients are often treated by the same providers, while the allocation mechanisms of the public and private funds differ. CSO figures from 2010 show that, of those patients with private health insurance who had been hospitalised as in-patients in the previous 12 months, over 60% were treated in public hospitals. A significant proportion of consultants, meanwhile, have contracts that allow for a mixture of public and private practice.

For hospital treatment, public hospitals and consultants are paid on a fixed basis (with some adjustment for casemix for hospitals) for treating public patients, while they are paid on a fee-for-service basis for treating private patients. Treating more public patients therefore does not yield more income, whereas treating additional private patients does, thereby creating an incentive to treat more private patients. I am aware that moves are under way to roll out a money-follows-the-patient system in public hospitals, but depending on the relative reimbursement rates for public and private patients, there may still be an incentive to favour private patients even under this new system.

Although Ireland is not unusual in having a mixture of public and private funding and delivery mechanisms, where we are unusual is in the degree of
overlap between them. This overlap does not all go in one direction either, as some public patients have been treated in private hospitals under the National Treatment Purchase Fund. On the funding side, the State partially subsidises the purchase of private health insurance, the most obvious subsidy being the tax relief at source granted on private health insurance premiums, although this was capped in 2013. Meanwhile, public hospitals receive hundreds of millions of euro per year from private health insurers for the treatment of privately insured patients.

I believe that one focus of the Committee’s plan for the next 10 years should be to try to disentangle this overlap between public and private funding and delivery. The Committee’s Terms of Reference refer to “the need to establish a universal single tier service where patients are treated on the basis of health need rather than on ability to pay.” Although this is a noble aspiration, I do not believe that an entirely single-tier system for all health services is achievable, given that the private health insurance market and the private hospital system are both well established. Rather than try to eliminate these, consideration should be given to what role they will play in the Irish health system into the future. Bearing this in mind, the concept of a universal single tier service needs to be defined, as the destination will determine the route to get there.

That being said, I believe that it is important to try to reduce the degree to which public patients seeking treatment in public hospitals are impacted by the treatment of private patients in these same hospitals. One possible way of doing this would be to move to a situation where public hospitals are used to treat public patients only (bearing in mind that those with private health insurance do not forsake their right to be treated as public patients). It may be considered acceptable for those with private health insurance to use that insurance to pay for better accommodation, but not to receive faster access. This would, of course, require contract renegotiations with consultants and additional State funding for public hospitals.

If access issues facing public patients in public hospitals were addressed, then this would remove one of the main drivers of demand for private health insurance, thereby naturally reducing the two-tier nature of the hospital system.

It should also be borne in mind that, while the Irish health system is often referred to as a two-tier system, where private patients are better off in terms of receiving services than public patients, it is actually more nuanced than that. While it may be the case that private patients are better off in terms of hospital treatment, the opposite is often true at primary care level, where services are provided free at the point of use to those with medical cards, and GP visits are
free at the point of use for those with GP Visit cards, while private patients – i.e. those who are not in possession of a medical card or a GP Visit card – must pay significant out-of-pocket charges for services.

In this case, those who have to pay privately may be reluctant to access services because of cost. Indeed, research has shown this to be the case. One paper, by Dermot O’Reilly and others, published in 2007, showed that over 26% of those without medical cards had put off going to see a GP on cost grounds in the previous 12 months, compared with fewer than 5% of those with medical cards. While some of these people may get by without seeing a GP, undoubtedly in some cases the delay in seeing a GP will contribute to the illness getting worse before they eventually have a consultation, which may result in some of them requiring hospitalisation, which is a far more expensive form of treatment.

The removal, or at least reduction, of the financial barrier to accessing GP services should therefore be another priority of the 10-year plan. Although moves have already been made to do this, with the roll-out of universal entitlement to GP Visit cards for the over-70s and under-6s, I believe that priority should now be given to those on lower incomes rather than those in certain age brackets. GP Visit cards do not give increased access to GPs per se, but rather they remove the financial barrier to accessing GP services. This financial barrier is more acute for those on lower incomes, for whom the cost of a GP visit, which averages over €50, represents a significant proportion of their weekly income. Therefore, I believe that serious consideration should be given to raising the income thresholds for GP Visit cards. While this might be more administratively cumbersome than rolling out eligibility by age group, I believe that it would be more beneficial to those who struggle to afford GP services.

It should also be remembered that it is not just GP services that pose financial challenges for people. For those without medical cards, the Drug Payment Scheme threshold, which must be met before the State funds prescription charges, is €144 per month, which represents a significant proportion of many households’ income. Furthermore, this threshold has increased since the onset of the economic downturn, as have a number of other charges (as shown in Table 1), while prescription charges were also introduced in 2010 for those with medical cards, and these have also been increased since then.
Table 1: User Charges for Selected Medical Services in Ireland: 2007-2016

<table>
<thead>
<tr>
<th>Year</th>
<th>DPS Threshold (per month)</th>
<th>A&amp;E Charge (without GP referral)</th>
<th>Inpatient statutory bed charge (per night)*</th>
<th>Prescription charge (per item) and monthly limit (per family)</th>
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</thead>
<tbody>
<tr>
<td>2007</td>
<td>€85</td>
<td>€60</td>
<td>€60</td>
<td>N/A</td>
</tr>
<tr>
<td>2008</td>
<td>€90</td>
<td>€66</td>
<td>€66</td>
<td>N/A</td>
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<tr>
<td>2009</td>
<td>€100</td>
<td>€100</td>
<td>€75</td>
<td>N/A</td>
</tr>
<tr>
<td>2010</td>
<td>€120</td>
<td>€100</td>
<td>€75</td>
<td>€0.50 / €10</td>
</tr>
<tr>
<td>2011</td>
<td>€120</td>
<td>€100</td>
<td>€75</td>
<td>€0.50 / €10</td>
</tr>
<tr>
<td>2012</td>
<td>€132</td>
<td>€100</td>
<td>€75</td>
<td>€0.50 / €10</td>
</tr>
<tr>
<td>2013</td>
<td>€144</td>
<td>€100</td>
<td>€75</td>
<td>€1.50 / €19.50</td>
</tr>
<tr>
<td>2014</td>
<td>€144</td>
<td>€100</td>
<td>€75</td>
<td>€2.50 / €25</td>
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<tr>
<td>2015</td>
<td>€144</td>
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<tr>
<td>2016</td>
<td>€144</td>
<td>€100</td>
<td>€75</td>
<td>€2.50 / €25</td>
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* Limit of 10 x nightly charge in a continuous 12-month period

These increases in user charges were introduced as a result of a shrinking public budget available for health services, and they, combined with significant increases in private health insurance premiums over the same period, led to an increase in the proportion of total health spending coming from private sources, from 21% in 2008 to 31% in 2014. As private sources of funding, including private health insurance premiums and user charges, are regressive sources of funding (meaning that those on lower incomes pay a higher proportion of their income) while public sources, including taxation, are progressive sources (meaning that those on higher incomes pay a higher proportion of their income), the shift from public to private sources has adverse implications for equity in the system.

As I mentioned earlier in the context of the healthcare triangle, citizens are the ones who fund health services. This is the case irrespective of the funding mechanism used. Therefore, the debate in terms of cost shifting is not so much about who pays, but rather about how the burden of payment is spread. Ideally this should be spread in as equitable a way as possible.

This raises the issue of how to fund public health services. The main options used around Europe are taxation, which is the main source of funding in Ireland, and social health insurance. The latter has also been proposed for Ireland. However, I believe that, rather than changing the funding mechanism, the focus should instead be on the allocation of funds and delivery of health services. One key focus should be any incentives that exist within the system or that are created by any redesign of the system.
It should also be borne in mind that significant improvements in the public health system in Ireland will entail significant costs. It needs to be acknowledged that the Irish system is under-resourced in a number of areas. According to OECD figures, we have 2.7 doctors per 1,000 population, compared with an OECD average of 3.3, and within our figures we have a lower than average proportion of specialists. The OECD figures also show that we have 2.8 hospital beds per 1,000 population, compared with an OECD average of 4.8. If we were to try to reach the OECD average figures, we would require 2,800 additional doctors and over 9,000 additional hospital beds. Although we currently have a younger than average population, which may mitigate these numbers to a degree, our population is growing and ageing, which will affect the demand for health services.

CSO projections suggest that our population will increase from 4.6 million in 2011 to somewhere between 5.0 and 6.7 million by 2046. Furthermore, the proportion of the population aged over-65 is projected to rise from 11.6% in 2011 to between 21.6% and 27.9% by 2046, while the proportion aged over-80 is projected to rise from 2.8% to between 7.2% and 9.4% over the same time period. Evidence shows that those in older age groups have, on average, higher utilisation of health services than those in younger age groups.

The ageing of the population, coupled with an increasing incidence of chronic illness, is engaging health policy makers in many countries, not just Ireland. However, as demonstrated by the resource figures above, our system is perhaps less well equipped to face these challenges. The Irish health system never fully recovered from the cutbacks in the late 1980s and early 1990s, and this is affecting our ability to meet the health needs of our current population, let alone provide for the anticipated increase in demand resulting from our growing and ageing population.

While one major area of focus is trying to keep people out of hospitals and ensure that they are treated instead at primary care level, and this is a worthwhile focus, it will require significant investment in primary care in order to ensure that resources are in place to fulfil this ambition. However significant investment will also be needed in our hospital system, which still has fewer beds than it did in 1980, despite a significant increase and ageing of the population over that time. While it is true to say that it is not all about money, it is also the case that what we want to achieve will not be achievable without significant additional funding.
I hope that this opening statement provides some food for thought for the Committee. I would once again like to thank the Committee for the invitation to appear here today, and I wish the Committee every success in its important work.

Thank you.