Joint Committee on Health

Opening Statement

Secretary General Robert Watt

Tuesday 24th October 2023

Introduction

Good morning, Chairperson and Members of the Committee. I am delighted to be before the Committee this morning to consider the funding of health services in 2024.

I am joined here by my colleagues from the Department of Health Resources Division; Louise McGirr, Assistant Secretary and Kevin Colman, Principal Officer.

Investment

Today we are discussing the budget allocation for the Department of Health of €22.5 billion for 2024 in the context of unprecedented investment in healthcare over the last number of years by successive Governments.

Since 2016 (excluding disability services which transferred to the Department of Children, Equality, Disability, Integration and Youth last March), the budget for Health has increased from €11.8 billion to the €22.5 for 2024.

In that same time, there have been record levels of recruitment with the number of whole-time equivalents (WTEs) employed rising by almost 40 per cent from 91,559 to 122,273.

On a like for like basis therefore we can see an effective doubling in spend over the last 8 years. This is more significant investment than most other developed countries. For example, if one looks at NHS England as a comparator you can see that its budget has increased in the same period from £102 billion to £169 billion.

Focusing on the last three years we have added 22,000 healthcare staff, including 6,700 additional nurses and midwives, 3,100 extra health and social care professionals and 2,500 more doctors and dentists.

Furthermore, the Government has increased our hospital bed capacity by over 1,000 and increased ICU capacity.

Affordability

The Minister has introduced a wide range of affordability measures in line with the Sláintecare vision of universal healthcare including;

- The abolition of inpatient hospital charges;
- Free contraception has been rolled out to women up to the age of 30;
- Access to State-funded GP care has been expanded to include 6- & 7-year-olds and all those up to the median income;
- The threshold for the Drugs Payments Scheme has been reduced to €80 per household per month.

The full year cost of these measures is over €240 million per annum.

Demand

This record investment is required to meet record increases in demand for health services. Ireland now has our largest population since 1850 and the profile of that population is aging markedly. For example, the number of people aged over 65 has risen by 21.7 per cent since 2016 based on the latest census.

It is interesting to consider the scale of the services being provided and the increases in demand faced by the acute system, in particular:

In the 12 months to June this year the HSE:

- saw over 3.5 million people in outpatient clinics;
- carried out 1.16-million-day case procedures;
- had 634,476 episodes of inpatient care and;
- saw 1.68 million patients in emergency departments and injury units.

These represent 178,000 additional patients treated in the year to date compared to last year.

As well as treating more people we also see improved outcomes for those patients who are treated. This can be seen across most specialities. But to take one example, the number of Irish people who are living after cancer has grown by more than half over the past decade as survival rates continue to improve. New and more expensive drugs and treatments, alongside more and better trained staff are to leading to better outcomes.

So, when we assess performance output indicators it is important to recognise that they don't tell the full picture – outcome indicators must also be considered.

Hospitals

While we have succeeded in increasing activity in our hospitals, and with better outcomes for our citizens, this has come at an increasingly high cost to the taxpayer.

Investment in acute care activity has increased by more than 80 per cent over the last seven years, from €4.4bn in 2016 to €8.1bn in 2023, with acute care expenditure now making up over a third of our overall spending. The hospital workforce has grown by 36 per cent over the same period.

Using an economy wide deflator of circa 25 per cent, this indicates *real* increases in expenditure of over 50 per cent.

The number of patients treated has not kept up with this large increase in resourcing however, with increases of between 10-20 per cent over the same period.

Even accepting improvements in outcomes, this presents a substantial divergence between resourcing and activity. This "productivity puzzle" can be attributed to:

- poor physical infrastructure due to previous under investment;
- lack of IT investment (including digitalisation) and low capital per person employed;
- weak processes and outdated pathways;
- inadequate consultant led leadership including an outdated contract.

New ways of working

Given this weak productivity, we need to look more deeply at how we are structuring our healthcare services to ensure that resources are used effectively. We share this challenge with many other countries as spending pressures in health services are outpacing government revenue at a time of ever greater healthcare need.

To meet this challenge, we are reforming and must continue to change how we deliver those services. As the health demands of our population continue to grow by 3-4 per cent per annum, we will have to develop innovative and sustainable means of meeting this demand. We already have examples of this.

We have spoken previously in this Committee about the new integrated services we have developed for older people, and those with chronic illness, through our Enhanced Community Care programme (ECC).

This programme is helping hundreds of thousands of people manage their health in their communities, outside of hospital. In the next week, ECC is extending to include an interface with public and private nursing homes to support post-hospital discharge. As part of this approach, it is expected that all patients transferring from acute hospitals to nursing homes will be assessed by, and necessary care interventions delivered by, Integrated Care Programme for Older People (ICPOP) and the wider primary care team as appropriate. This will help improve hospital avoidance, support early discharge, and reduce readmission to hospital.

In addition, care pathways need to be radically reshaped. We are developing 33 new modernised care pathways. For example, our Integrated Eye Teams for

Paediatric and Acute eye conditions is one such reformed pathway which is implemented as part of the Minister's 2023 waiting list action plan. This community-based service has this year achieved 5 per cent reductions in hospital waiting lists and a 50 per cent reduction in long-waiters in operational sites.

New "See and Treat "clinics are another example of reform. Over the last two years we have seen a 9 per cent drop in the Gynaecological outpatient waiting lists despite a 30 per cent increase in referrals. 14 of our 19 new See & Treat clinics are now open with a further two starting by year end. As a result, in Letterkenny for example, 99 per cent of women are seen in less than 6 months. In the Rotunda it is 93 per cent. By the end of 2023 an additional 15,000 women will have been seen due to this reformed way of care.

Our job is to replicate and scale these models so all of those who rely on our health service now and in the future can get the right treatment for them when they need it.

This will involve investment but also a relentless focus on innovation, change and reform. In other words, major gains in output and productivity.

Expenditure Pressures

Turning to expenditure for this year, we accept that the forecasts of health expenditure need to improve as does control of expenditure. We are responding to this challenge by improving our use of data, our analytical capacity, our performance oversight and corporate governance.

Savings and efficiencies are also required in the acute health sector and will form part of the Service plan which is being developed to give effect to the recent Budget.

Pay makes up 42 per cent of the budget. There are two principal drivers of pay expenditure, the number of people employed and the rate at which they are paid. Since 2016 the pay bill has increased by €3.2bn. Our analysis estimates that 51 per cent of this growth is related to the recruitment of 27,487 WTE additional staff and 49 per cent is due to pay increases centrally negotiated through public service pay deals.

Measures will need to be taken on recruitment, overtime and agency as set out by the CEO of the HSE.

Excluding medicines, non-pay in the acute sector includes expenditure on medical and surgical supplies, laboratory equipment, heat and lighting, cleaning, and maintenance.

This expenditure has increased by more than expected this year due to both demand and high prices. It is now estimated that expenditure apart from pay and medicines will be €2.376bn this year, €573m more than forecast.

For example, we now expect:

- a 23 per cent increase in expenditure on medical and surgical supplies;
- an 18 per cent increase in heat power and light to the end of the year;
- a 28 per cent increase in Laboratory costs;
- a 27 per cent increase in the cost of X-Ray/ Imaging;
- a 37 per cent increase in the cost of catering.

In these areas higher demand and prices are driving expenditure pressures.

We will need to examine procurement processes and strategies and stock management to drive efficiencies in this area.

Medicines

A growing area of spend is in medicines.

The pharmaceutical budget has doubled in the last decade from €1.3bn in 2012 to €2.6 billion in 2022. This year expenditure is likely to be €2.9 billion. Including payments to contractors such as pharmacists, this expenditure rises to an expected €3.2 billion by end 2023.

This is nearly €1 in every 8 of public funding on health.

This level of growth is not sustainable, and we need to strive to maximise the available investment to provide as many people as possible with access to medicines.

The pipeline of new medicines is strong. Higher prices for innovative medicines are a key contributor to growth in pharmaceutical expenditure.

Next year, for example, the first of a new class of drugs for Alzheimer's disease is expected to launch. Lecanemab if approved, could have a budget impact of €100m annually at list price in Ireland based on 4,000 patients requiring treatment.

We can though do much more I believe to better use the existing budget we do have by using generic and biosimilar medicines.

The arthritis drug adalimumab for example consumed more of the high-tech drug budget than any other medicine (€106m to end of August 2023) and the number of patients requiring it continues to grow.

To address these costs a Best-Value Biologics programme was launched to make use of biosimilars rather than the branded version of adalimumab. As a result, 80 per cent of patients moved to a more affordable biosimilar.

Recently the manufacturer of the branded biologic has dropped its price to remain competitive with biosimilars in Ireland. Since this price decrease, both the branded biological and biosimilars of adalimumab can be used by patients without paying a premium.

Savings from this class of drug alone are projected to reach over €100m by the end of next year.

It is this type of reform that we need to do more of in order that we maximise value not just in medicines but across the health service.

Conclusion

In conclusion, we need better budgetary control, more efficiencies and savings in the short term while continuing to deliver reform of our Health services.

Sláintecare offers a roadmap for achieving this reform and productivity as we need to deliver greater amounts of care closer to home and promising more accessible health services at a lower cost.

We need improved pathways, new ways of working and further development of our community centred model of care.

Public Health initiatives, in particular the early and continuous prevention of illness, and the promotion of healthy ageing will be integral to the effective functioning of our future healthcare system.

There is simply no prospect of continuing to treat ever increasing numbers of sick patients in acute hospitals under our existing structures and pathways. Ultimately, we are aiming for a country where patients are able to live longer, better lives, and are not only treated, but supported by our healthcare services in achieving this.

Thank you.

Ends.