

DÁIL ÉIREANN

COISTE UM CHÚRAM SLÁINTE SA TODHCHAÍ

COMMITTEE ON THE FUTURE OF HEALTHCARE

Dé Céadaoin, 20 Iúil 2016

Wednesday, 20 July 2016

The Select Committee met at 9 a.m.

MEMBERS PRESENT:

Deputy Mick Barry,	Deputy Billy Kelleher,
Deputy John Brassil,	Deputy Alan Kelly,
Deputy James Browne,	Deputy Hildegard Naughton,
Deputy Joan Collins,	Deputy Kate O'Connell,
Deputy Michael Harty,	Deputy Louise O'Reilly.

DEPUTY RÓISÍN SHORTALL IN THE CHAIR.

Health Service Reform: Health Reform Alliance

Chairman: At the outset may I remind members, witnesses and observers in the public Gallery of the importance of ensuring their mobile phones are switched off because it causes serious problems for broadcasting, editorial and sound recording staff? I ask members to co-operate with that request.

I am delighted to welcome everybody to the all-party Committee on the Future of Healthcare which is holding its first public stakeholder consultation meeting this morning. This committee was established by a motion of the Dáil on 1 June in order to agree to an all-party ten year plan for the future of the health service; to identify a pathway towards a universal single tier health service and to achieve consensus on a new health care model based on need. The committee will report to the Dáil based on its examination of expert research, analysis of stakeholder submissions and evidence heard during its public hearings.

To date the committee has held four briefing sessions on a number of topics, including a factual overview of the role of the Department of Health and the organisational structures of the HSE, an overview of existing and ongoing research of relevance to the committee's terms of reference and a workshop session by Dr. Eddie Molloy on strategy design.

Last week the committee officially launched its public consultation exercise. There are more details about the public submission process on the committee's Oireachtas website. The closing date is 26 August and I would strongly encourage any interested stakeholders, patient groups, health care organisations, researchers and members of the public to make a submission to the committee using our web page.

I welcome representatives of the Health Reform Alliance to our meeting this morning. The Health Reform Alliance is an umbrella group representing organisations that support patients and clients of health and social services. We are joined by Ms Cliona Loughnane, policy and research manager of the Irish Heart Foundation, Dr. Marita O'Brien, policy officer of Age Action and Mr. Paul Gordon, policy officer of the Irish Cancer Society.

I advise the witnesses that, by virtue of section 17(2)(l) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by it to cease giving evidence on a particular matter and continue to do so, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or an entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing ruling of the Chair to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official, either by name or in such a way as to make him or her identifiable.

Ms Loughnane will lead off with an opening statement and Dr. O'Brien and Mr. Gordon will contribute to the questions and answers session with members.

Ms Cliona Loughnane: I thank the committee on behalf of the Health Reform Alliance for inviting us to make a presentation today. We wish the committee the best of luck in the challenging task ahead, but we believe the potential exists for a really rewarding and fruitful exercise. Let us go back in time to July 1948, when a leaflet emblazoned with the title The New

National Health Service was dropped into letter boxes across the UK. It stated:

Your new National Health Service begins on the 5th July. It will provide you with all medical, dental and nursing care. Everyone - rich or poor; man, woman or child - can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not 'charity'. You are all paying for it, mainly as taxpayers and it will relieve your money worries in times of illness.

The Health Reform Alliance see this committee as the crucial next step in the development of Ireland's health and social care system as a universal system by 2026. We all dream of a similar leaflet drop or e-mail being sent to every member of the public in Ireland ten years from now.

This committee - with a remit to support the Oireachtas adopting a ten-year plan for health care - has an important task. The committee will be watched closely and supported by people who use the health and social care system.

Let me introduce our alliance, summarise the problems we see, and focus on three solutions which we hope the committee could use as they progress with the work.

Lone voices representing particular patient groups, as all of our organisations do, are often sidelined in the debate about health reform. Reflecting this, the Health Reform Alliance, HRA, was established as a small group of organisations in 2014 with shared concerns about the health service. The current members of the HRA are the Adelaide Health Foundation, Age Action, the Asthma Society of Ireland, Irish Cancer Society, Irish Heart Foundation and Samaritans. We shared a common belief that reform was needed to create a more equitable system. Our main purpose was to develop consensus on the values we believe should underpin reform and to advocate for the policies, systems and services that could best deliver on those principles.

We launched our charter of five principles in January 2016. A copy of the charter has been circulated to all members. We held a consultation event in May which led to more than 30 organisations seeking to join the alliance. We are growing our membership at present. We hope to be a force for change in the system.

The alliance believes that the main problem, which has been identified in the remit of the committee, is that the Irish health system unlike most health systems across Europe, has not developed as a system offering universal access to health care. Our system is regrettably unique. It is a tax based system that fails to provide universal access and which has significant user charges for certain elements of the service.

Without wishing to rehash common complaints about the system that one hears on the airwaves regularly, it is important to discuss why our organisations felt compelled to come together on the issue of health reform. As patient organisations, our organisations hear from people facing difficulties accessing the care they need. We support people who cannot access a hospital bed or a homecare worker; who are subject to different eligibility criteria depending on their location; who are 'too late' to access nursing home care subject to a yearly budget cap; and families who are forced to navigate the very difficult situation between hospital and community care. We are acutely aware of how the confusing mix of public and private health care creates problems for people who are treated differently whether they have insurance or a medical card. Conversely, in the social care system, people without a medical card seeking respite, can be refused because they are so-called private patients. Clearly, the system is not suited to meeting

the needs of the 21st century. Yet, at the same time we recognise that good care still happens. People will talk about a nurse who took additional time to comfort them, or a GP who showed real skill and compassion in dealing with their case. These too are real experiences of the health service. Yet, unfortunately they are diminishing in comparison to tales of consultant appointment waiting times, people waiting for a potentially life-changing diagnosis, spiralling health insurance costs and emergency department overcrowding. That is a summary of the problems.

The committee is here to talk about solutions. We propose three solutions which could be effected through the committee's approach to developing a ten-year plan. These would help to achieve our charter principles creating a system which treats everyone equally, taking account of specific needs; provides clear entitlements; integrates care; and is underpinned by a universal, publicly funded system.

We urge the committee to focus on the outcome to be achieved - that is the healthcare system to be delivered by 2026. To date, much time has been taken up with funding models, comparing one country against another. Much less time has been given to what should be the primary concern, namely what we expect the healthcare system to deliver. It seems to put the cart before the horse to talk about how to pay for a system before we decide what we are paying for. The role of this committee is to plan for 'a universal single tier service'. By achieving this goal people will be liberated from the two tier system. The first step must be a clear definition of what universality means in the Irish system. A universal system would require a commitment by all to pay into the system so that we can receive equal care for equal need. While we will not be able to provide all forms of care to all people, whatever care is available should be available equitably and without discrimination. Such a system – organised through the funding model that is decided – must share the burden of illness collectively, where healthy people subsidise the sick and high income earners subsidise low earners.

Delivering a universal system within a decade is certainly a challenge for legislators and policy makers. We believe sustained commitment and backing of this vision over that period will require a clearly communicable vision which energises supporters. There are so many supporter across the country who want the ten-year plan to succeed. This clearly communicable vision can make it difficult for vested interests, who may not wish to see a strong public health system and make it difficult for them to subvert or derail the plan.

Second, we propose the committee would design a vision for a health and social care system. The experiences of the people we represent indicate the deep interconnection between health and social care. Need for medical care or personal care cannot be clearly divided in the lived experience of being unwell, yet policy up to now has dealt with health and social care needs differently. While health need is to some extent dealt with in the public system, social care is primarily viewed as an individual responsibility subject to heavy means-testing. This reflects a poor law view of social care as 'charity' for the destitute. The lack of designated funding for social care forces many families to place a loved one in residential care prematurely, when home help, day-care or respite care could have helped to keep their loved one at home. Consequently, vital social care services are increasingly available only to those with the highest needs and lowest incomes, rather than as a universal service supporting the whole population to be well.

Third, we believe the ten-year plan should focus on the public system and should pragmatically deal with the system as it currently exists - primarily a tax funded system. Taxes paid for 77% of health expenditure in 2013 and yet, in our primarily tax-funded health system, people with private health insurance have quicker access to health care than their fellow taxpayers

without insurance. Policy debates often emphasise the lack of private health insurance as the problem within our system. This appears to overlook the fact that the vast majority of spending on health care comes from taxation with insurance covering less than 10% of health costs. Furthermore, it is likely the reason many people hold health insurance is they do not believe they will receive adequate health care without it and so we urge the committee to focus its attention on the tax-funded public system.

The alliance believes that discussing, arguing if necessary and then reaching consensus on a vision for 2026 is the most important task this committee can achieve, after which will start the hard work of implementing and achieving that vision. The alliance, however, urges members to take heart because as Aneurin Bevan, the architect of the NHS in Britain, stated: “The NHS will last as long as there are folk left with the faith to fight for it.”

Chairman: I thank Ms Loughnane. I will now open up the meeting to members for comments or questions.

Deputy Billy Kelleher: I thank Ms Loughnane. Briefly, while everyone present probably is in agreement about how we should strive to achieve a universal health care model in the years ahead, the difficult parts will be the stepping stones to get there. It probably is fairly easy to reach broad consensus on the vision but the difficulty will be in trying to implement it in terms of policy, legislative underpinning and funding over the next number of years. In that context, Ms Loughnane referred to taxation being the main funding base for the public health system and then referred to how private health insurance only accounts for 10% of it. In that context, how does she envisage moving over time to a publicly-funded taxation-based model with universality at its core? Moreover, if one extrapolates on all the current intertwinings of the private health insurance and health care providers, even down to consultants’ contracts and so on, how does she perceive its unwinding over time, essentially to push private health care completely out of the public system?

Chairman: If Ms Loughnane can bank those questions, we will take three speakers at a time.

Deputy John Brassil: I thank Ms Loughnane for her presentation. I have two broad but brief questions. Does the alliance envisage a role for private health care in some shape or form in a new model? As some people may choose that as their preference, does Ms Loughnane perceive that to be something we should include in our strategy? Second, does Ms Loughnane believe the HSE structure as it stands at present is capable of delivering what she set out in her presentation?

Deputy Hildegard Naughton: I also thank Ms Loughnane for her presentation. One main point she raised was the need to focus on the outcome, as opposed to the funding model, and she stated that focusing on funding is putting the cart before the horse. Committee members fear and wish to avoid producing another report that sits on a shelf because they have not taken cognisance of how the model will be funded. While it is important to lay out a vision as to where we are going over the next ten years, from my perspective we must be cognisant of how we will fund that vision at different points along that ten-year period and beyond. Ms Loughnane made reference to Aneurin Bevan, the Labour Party Minister in the United Kingdom, and when one considers the public system in which universal health care is available, is there evidence within that universal system of a move away from private health care? On the point that public care expenditure accounted for 77% of health spending in 2013, does private insurance account for the majority of the remaining expenditure on health care?

Ms Cliona Loughnane: If it is all right, I might just respond to the questions and then open them up to my colleagues.

Chairman: Yes, certainly.

Ms Cliona Loughnane: I might take the easy question first. The figure of 77% for taxation funding of the health service comes from the recent ESRI report on universal health insurance, UHI. It is based on 2013 figures and states that 9% comes from private health insurance. That is the reason I indicated that less than 10% comes from private health insurance. The other 12% comes primarily from out-of-pocket payments. This, for example, involves people paying upfront for their general practitioner, GP.

Chairman: It could be payment for their GP, their consultant or their drugs costs.

Ms Cliona Loughnane: Yes, I apologise, that was just an example.

A number of questions related to private health insurance and the reason we are talking about a tax-funded model. In the Health Reform Alliance, as Deputy Naughton mentioned, we are focused on the outcome. All we really care about in this process is that the quality of care for patients is maintained and then improved and that the outcomes for patients are better. We would not claim to be the experts as to how we get to that system, we are really focused on patient outcomes. As for the reason we are talking about the tax-funded system, it is based on not developing a system from nothing. We must work with the historical system we have inherited and the evidence shows that our system is really a tax-funded system. Moreover, until we can show that disrupting this system or moving to a completely different model would be more effective, it seems that the pragmatic approach is to work with the system we have and see how we can improve it. In its recent report, the ESRI also made the point that it is pragmatic, particularly in primary care, to consider how one can extend out tax-funded access to universal access to primary care, because that is how it is going at present in the increased provision of medical cards for different ages and medical needs and so on. Consequently, the reason we are talking about the tax-funded system is it seems that we have inherited a certain system within which we should work. In addition, I am sure members have heard evidence from health economists that tax-funded systems tend to be much more efficient. They tend to be less costly because of their nature. One is pooling together all the funds and there are economies of scale. One is not obliged to account for the cost of competition, for marketing between different health insurers and so on. The evidence appears to lead us towards a taxation-funded model or a social health insurance model if we are talking about an efficient, affordable system.

As for private health insurance, we all accept there always is a role for private health insurance and probably always will be. I do not believe there is any system in the world that does not have some level of private health insurance. The Irish system is particularly unusual because upwards of 40% of people hold private health insurance at present but as I stated, its actual contribution in paying into the system is quite limited. When one looks at how a person benefits from private health insurance, one really is getting early access to a consultant, as well as access to diagnostics, that then allow one to access the public health system. Again, this is a unique aspect of the Irish system. In other systems, if one had private health insurance, one more than likely would be treated by a private consultant in a private hospital. However, within the system we have, one has private health insurance but actually is treated by somebody in a public hospital on a public contract who is using the portion of his or her contract that is for private health insurance. It is an agreed part of our system but it is highly unusual. The Health Reform Alliance certainly would not state that we do not envisage any role for private health

insurance. It is a choice that people will make. It simply appears that in Ireland, a great number of people seem to be making that choice because they have difficulty accessing the public hospital system.

There was a question on whether, as one moves towards universal provision, a move away from private health insurance can be discerned and that certainly is the case. As I stated, the level of private health insurance in Ireland is highly unusual. I am not entirely sure of the figures in the United Kingdom but I think fewer than 10% of people hold private health insurance, which indicates that because they can get access to the service, there is not the same level of requirement. Again, within the NHS it is split into two systems, whereas in Ireland we have a layering together of the two systems. There was another question about the HSE, its structure and whether that is capable of providing a universal service. That is a very broad question. We were talking outside earlier about some of the real gains that have been made by the HSE in recent years, particularly in the clinical care programmes and in respect of models of care. The Irish Heart Foundation is particularly interested in stroke. There have been real developments in how stroke patients are being cared for, particularly in the acute service. The HSE definitely has the potential to provide care of a good quality. It is a question of how we can improve the structure we have in Ireland. There are different types of tax-funded systems. We have a single provider of care - the HSE - in Ireland. There are multiple providers in the UK as a result of the system that was introduced there in the 1990s. Even if we decide to focus on a tax-funded system, we will have to consider the various ways of providing for that. As has been said, a number of decisions have to be made along the way.

Dr. Marita O'Brien: I would like to speak about integrated care. The barriers to integration include the separate funding streams that exist at the moment. The HSE funding is divided into separate streams. Each section is very protective of its budget. For that reason, it is very hard to make changes in the social care system. We have never developed assisted living or anything like that because of the way the budgets are streamed within the wider Department and the HSE, which are very much focused on health. In other countries, there is more local authority involvement on the ground. The integrated care model envisages that health and social care should be integrated in a wider sense in communities. There tends to be a great deal of segregation in Ireland. The Department of the Environment, Community and Local Government has its budget and the Department of Health has its budget. At the moment, there are separate budgets. If a new funding system with moneys from each Department were to be developed, there could be more integration. That would allow people to develop. The suggestion at the moment is that having differentiated budgets is a barrier to integration. It would be preferable if the HSE could have more integration within its budgets. The acute care system uses up much of our funding. Primary care and social care tend to come further down the line. If there was a way of working to avoid the hierarchy that exists at present, that would help as well.

Chairman: What is Dr. O'Brien talking about when she refers to the Department of the Environment, Community and Local Government's elements of this system? Is she talking about types of housing?

Dr. Marita O'Brien: Yes, I am talking about housing with care-assisted living. The Department of the Environment, Community and Local Government can build houses for older people or people with disabilities, but it does not want to take on the provision of services because that would have to come out of its budget. It needs to be helped if it is going to be involved in providing that budget. At the same time, the Department of Health cannot commit to a certain level of funding unless it has details of the assessed needs of those who are going

to be using these houses. Perhaps the additional integration that is needed can be facilitated by establishing a budget system in which each Department commits to provide a certain proportion of the money needed to support a person's living and health care needs. Maybe we could put them together to further promote that kind of approach.

Chairman: We are all conscious of the problems with housing adaptation grants not being in line with health care.

Dr. Marita O'Brien: Exactly. If people do not have budgets, that can delay discharge from hospital. People in some parts of the country are not put on the list until that point. As a result, the waiting lists really do not reflect people's needs. Someone at the sixth or seventh point on the scale is recorded as waiting. A hospital patient who needs some adaptation will not get it in time, so he or she will go to a nursing home. Those kinds of issues can arise.

Mr. Paul Gordon: I would like to build on the point made by Ms Loughnane. I think there will always be a role for private insurers. People will always want that option. We need to build confidence in the public health system so that there is less reliance on private insurance. Our hope is that ten, 15 or 20 years from now, people will feel they can have confidence and pride in the public system and do not necessarily need to take out private health insurance to jump the queue.

Chairman: I would like to pick up on the point made about the experience in other countries. Given that 77% of the budget is tax-funded, it is obvious that there is a high level of subsidisation of private patients in this country. Would that be very unusual in other countries? It has been mentioned that approximately 10% of people in the United Kingdom have health insurance. Is it entirely private or is there any element of public subsidisation?

Ms Cliona Loughnane: I am not sure. There may be an element of public subsidisation. The manner in which Ireland subsidises private health insurance is very unusual by international standards. There are the usual semantics when people talk about subsidies, but it is really a cost to the system. The *sui generis* way our system has developed is quite unusual, as is the way subsidies have increased over time in line with the increase in the number of people who hold private health insurance. That meshing of the two systems is particular to Ireland.

Chairman: It is remarkable that private health insurance is contributing a figure of 9% to the health service. I think that figure is surprising for most people.

Deputy Louise O'Reilly: I thank the delegates for their presentation. I have a few questions about the current structure, such as it is. I am reminded of the saying that if we want to get there, we should not start from here. Of course, we are where we are. Do the delegates believe the Department of Health or the HSE should be the greatest driver of the introduction of universal health care? Do they think the Department and the HSE should work closely together or should they be further apart if they are to achieve the changes necessary? We can all identify the problems. We can see them. I welcome the suggestion that we should focus on the outcome rather than the issue. It is important to follow that point by saying we need to focus on the need to achieve value for money when we are spending taxpayers' money. I would be interested to hear the views of the delegates on the National Treatment Purchase Fund. My personal view is that because it involves spending taxpayers' money in the private sector, it is almost more counter-productive for the public health service than private health insurance providers. It is like changing from driving on the right-hand side of the road to driving on the left-hand side. It cannot be done gradually; it must be done all at once. Do the delegates believe there is a point

at which the leaflets will start to drop, or do they see it as a more gradual process? I would specifically like to hear their views on the National Treatment Purchase Fund and achieving value for taxpayers' money.

Deputy Michael Harty: I would like to get the views of the delegates on a few of my ideas on how the system can change. There is general consensus that moving more services to primary and community care settings is the way to go. As people come before the committee, we are hearing that primary care is the pillar on which the health service will change. A great deal of unnecessary work is being put into hospital medicine. I refer to chronic illness cases, for example, which do not need to be treated in a hospital setting. The other side is that a great deal of necessary work is not being done in hospitals because of a lack of access to diagnostics. There is a difficulty in integrating primary and secondary care services. There is a difficulty with communications between primary and secondary care services. All of these problems lead to increased and unnecessary costs. There is a lack of capacity in the public system. There is a lot of wastage in the public system because of the lack of integration and communication.

Many areas of the HSE work very well. Certainly, cardiology services have improved beyond all measure. Colonoscopy services in my local area have improved dramatically in recent years, although I accept that this improvement may not be universal. Breast cancer and other services have also improved dramatically in recent years, in many cases on foot of adverse incidents that led to momentum for change. However, as somebody said earlier, the general system is not fit for the 21st century. I think many costs could be saved through integration and improved communication. We are tending towards bolstering primary care services. I would like to get the delegates' views. I agree with Deputy Joe O'Reilly that using the National Treatment Purchase Fund is like putting the cart before the horse or a band-aid on a problem. If the money was being put into the public service, it would prevent people from having to access the National Treatment Purchase Fund. I would like to hear the views of the delegates on how we could transfer services to the primary care model.

Deputy Mick Barry: I thought Ms Loughnane's presentation was very interesting. I am keen to pick up on the point she made about tax-funded systems being more economical. There is probably a perception that a tax-funded system based on taxes paid by the general public for the purposes of a more egalitarian system probably costs more. It was interesting to hear from experts who believe it would cost less. Ms Loughnane painted some broad strokes in respect of how it might cost less or how it actually costs less in practice. She gave the example of economies of scale and less competition within the system. I am unsure whether the members of the deputation would need to consider the issue before sending in material, but is it possible for them to go into that in a little more detail? Could they set out the broad strokes, how it plays out and the nature of those savings? I am keen to hear a little on that.

My other question relates to moving in the direction of the tax-funded system and a public health system in this country. What are the issues posed by where we are now? In particular, I have in mind the issues with where we stand regarding church and State within the health service in terms of ownership of hospitals and boards of hospitals. How great an issue is that? How does the deputation envisage this playing out in terms of moving towards a tax-funded, publicly-run system?

Chairman: Deputy Barry thinks of all the easy questions.

Mr. Paul Gordon: I will take the questions of Deputy O'Reilly and Deputy Harty first. I agree with many of the points Deputy O'Reilly made on the National Treatment Purchase

Fund, NTPF. The Irish Cancer Society has done a good deal of work around waiting times for colonoscopy procedures. We have found that the use of the NTPF is effective in the short term. However, it is expensive and I am unsure how sustainable it is. Probably, it asserts the primacy of the private system over the public system in terms of access to diagnostics. At present, it is a useful tool in reducing waiting times. However, there are ways to improve the system, for example, through better linkages within hospital groups. Certain hospitals have huge colonoscopy suites and only five or ten people on their waiting lists, while other hospitals in the same group might have large waiting lists and large numbers of people waiting over three months. There does not appear to be joined-up thinking. This has improved in recent months, with a clinical lead appointed to head the national endoscope working group. We hope that will improve matters. On the whole, there are other ways of improving access to diagnostics.

This links to Deputy Harty's point. There have been improvements in colonoscopy services but up to 46% of people are currently waiting over three months. The HSE guideline is that 100% of people should be seen within three months. That is significant. The NTPF initiative has worked, but only for a period of one or two months. There must be sustained investment and I am unsure whether it is affordable.

The question on primary and community care is apposite, especially in the context of the work of this committee. We are facing into a chronic disease crisis and a cancer crisis - I am not being flippant in saying as much. Cancer incidence will increase by 50% over the figure for 2010. Chronic disease accounts for approximately 78% of all deaths or mortality in the country. We know that 80% of chronic diseases are preventable and that 40% of cancers are preventable. Certain measures help, such as investment in programmes like Healthy Ireland and other health promotion initiatives. Often, these measures require targeted intervention in disadvantaged communities, where the rate of chronic disease is far higher than in the rest of the population. I hope I have covered those points.

Chairman: You made a point about facilities being under-used in hospital groups while there are long waiting lists in other hospitals. What is the reason for that? Is it an organisational issue? Is it local politics?

Mr. Paul Gordon: I am not entirely sure. It may be simply a question of competition between hospitals in the same group or particular consultants wanting to have ownership of the list, but I do not have a definitive answer.

Ms Cliona Loughnane: I will address Deputy O'Reilly's question on the structure and vision and whether it is a matter for the Department of Health or the HSE. There was also a question about when the leaflet drop would happen in Ireland. From our perspective, it has been positive to see the remit of this committee include consideration of a universal single tier system. It is a major development in the Irish health policy sector to strive for that position. Until recently, it was seen as a partisan approach to be interested in universal access to health care. We have come a long way already in that there seems to be cross-party support for the idea of a universal care system. We are far closer to a leaflet drop than we have ever been in the past.

There was a question about coming up with a vision. It seems to be for the Oireachtas to come up with a vision and then it is to be implemented through the Department of Health and the HSE. Obviously, the Department of Health and the HSE would have a major impact on how that vision is constructed because they are experts in the delivery of care and policy. *Ad hoc* policies are emerging all the time throughout the system. There was a news story today about access to medical cards for people in receipt of the domiciliary care allowance. That seems like

a good development but all those developments are taking place without a vision. Therefore, the quicker we can have a vision, the quicker we can commit to what we mean by “universal” in the system. We believe this is what the committee needs to take by the horns. It needs to define what we mean by a universal system, what is in and what is out, who is covered and so on. While there is cross-party commitment to universality, what do we mean by universality in the Irish system?

Deputy Harty began a conversation around moving to primary care and integration between services. I imagine committee members will hear this from almost everyone who comes before the committee. That seems to be the solution to many of the issues we have at the moment. As Mr. Gordon noted, one of the main reasons for this is that disease in the 21st century is chronic disease and multi-morbidity is a feature. The system we have is not really set up to care for people in that way. In the 19th or 20th century if a person was lucky enough to get in to hospital, she would have been in hospital for a short period and then come out better, all going well. Instead, now people are living with disease for long periods and they need to be maintained and managed in the community.

Dr. O’Brien pointed out that our budgets are not really set out to cater for that. We have acute hospital budgets and primary care budgets as well as limited social care budgets. We need far more integration of budgets. As Dr. O’Brien said, often the way funding is available will influence how care is delivered. Integration across budgets seems to be a sensible way to do that.

As we outlined in our opening statement, we are keen for the committee to consider the health system in the round. The health system includes home help and the factors that keep people well in the community. There have been *ad hoc* developments, for example, the fair deal scheme. That has been useful to help people get in to nursing homes. However, it seems to have prioritised nursing home care over people getting the support they need to live at home. We need to think about health and social care together, because in the 21st century, health is often related to social care.

Deputy Harty referred to improvements in the HSE and health care delivery. As Mr. Gordon said, sometimes we see improvements in one area only to see problems in other areas. Certainly we accept that moving to the centres of excellence and the development of the models of care across different chronic diseases are appropriate. We are seeing positive developments but they are not available throughout the country. That is the issue. A stroke survivor living, for example, in north Dublin does not receive the same service as a similar survivor living in Cork. Given that we are moving towards universality in the system, one would expect people to be able to access the same services across the country.

On Deputy Mick Barry’s questions about the tax-funded system, I could give him the broad brush stroke answers in terms of economies of scale and the lack of competition. We could also submit considerable evidence from different countries, including the Scandinavian countries which have tax-funded systems and the United Kingdom. We recognise that there are other ways to provide a universal system. For example, social health insurance is another model in which funds are pooled. It appears to be less expensive than private health insurance delivered models. It is said, with respect to taxation-funded models, that social health insurance models can have higher administration costs attached to them and so on, but there is a good deal of evidence that we could provide for the committee.

The ESRI has been charged with undertaking research projects to examine the different models and costings. I am not sure how its timelines meet the committee’s, but any evidence

the committee could obtain from that process would be very useful. As we discussed, the Irish system is unique. Therefore, evidence from other counties would be useful to a point, but we also have to deal with the situation in Ireland.

I did not expect to be asked a question on the issue of church and State with respect to health reform, but it is an interesting one. In preparing for the meeting and trying to figure out why the Irish system was so unique, one point that popped up was that we seemed to move away from our European neighbours in developing a universal system in 1951 with the introduction of the mother and child scheme. There was controversy in the development of the health system and we have moved along a different path from that followed in other countries, but this is not an issue that has come up in our discussions. The issue of hospital ownership by the church is not one we have faced. It does not appear to be an issue from our point of view and it is not something we have considered.

Chairman: It is a very interesting question though and potentially a major blockage in moving to a universal system. We might consider who might be in a position to talk to us about it because it is an important point.

Ms Cliona Loughnane: Yes.

Mr. Paul Gordon: To return to Deputy Michael Harty's point about communication with acute care services, we commissioned a report which the Irish College of General Practitioners, ICGP, undertook for us earlier this year to survey GPs on the issue of access to diagnostics. We found that one problem was communication after a diagnosis. Approximately 30% of doctors said there was very little communication with consultants afterwards. That is problematic in managing chronic illnesses. As a general practitioner, the Deputy knows that there are certain low level solutions to certain problems. There is a large health literacy problem among the population. GPs and consultants tend to underestimate the level of people's health literacy. Approximately 40% of the population encounter such difficulties.

Another issue in the system concerns access to GPs. There is not only an issue with access to diagnostics. In Deputy Róisín Shortall's constituency, for example, there might be pockets where there would be only one GP for every 2,500 people, whereas in Dún Laoghaire where I live there might be one GP for every 1,600 people. There is a need to provide a certain incentive for GPs to move into deprived areas because not only are there fewer GPs in them but also people living in the most deprived areas present with more comorbidities. There are more complex cases and because of the pressure exerted on GPs in these areas, they get to spend less time with patients who need more time.

Dr. Marita O'Brien: In response to Deputy's Michael Harty's questions I would add a further point about capacity in primary care services. The Health Research Board produced an interesting report on the integration of health and social care services. It examined different ways of providing for a more integrated approach, especially in health and social care services. It gave good examples of measures such as capitation. If capitation was provided for local populations in primary care centres, they would have to manage people's health from the cradle to the grave. Therefore, they would be incentivised to take prevention measures into account, intervene earlier rather than wait until crisis point was reached when people would end up having to enter the acute care system. It is a more locally developed approach at a local area level, a population based health model but with a local based approach to it. There are some examples of that in Australia.

There is reference in the report to the Kaiser Permanente Medical Group, a not-for-profit group in the US, that take this type of approach and it seems to have very good outcomes on evaluation. There are a few different examples given in that report. Taking that approach, it must be based at a community level because, as Mr. Paul Gordon pointed out, different communities have different needs. In a disadvantaged area, the approach would have to be at a community level and account would have to be taken of providing for the particular needs of the population.

Deputy Alan Kelly: I was very taken by the witnesses' commentary on the necessity for this committee to point a direction as regards the future of health care. That is the massive challenge we have. There is a need for us to be realistic about what we can achieve. We will have to set out a framework, give guidance and point in a certain direction as regards a plan for the next ten years or more. There is also a need for consistency in political thought and direction, which we probably have not had for many decades. We spoke earlier about the fact that there is a kind of consensus on the need for some form of universal solution or plan. When we talk about universality, what does that mean to the witnesses as regards the type of services that would be available under a plan that we would direct and put forward, that would be realistic, meet expectations and be optimum?

Deputy Joan Collins: I thank Cliona, Marita and Paul for their input. The National Treatment Purchase Fund is a symptom of the crisis. It is like putting homeless families into hotels and paying a huge amount of money to deal with the issue. For the last number of years, we have seen the HSE, for example, in the case of children with scoliosis send them to hospitals in Britain to get the surgery they require. That is one of the problems we have to examine as part of our consideration of a universal health plan.

The witnesses spoke about acute care, primary care and social care. Social care provision is probably crucial, particularly with the demographics of our ageing population and older people needing care. It is expected there will be an increase in the demand for such care. I have had experience of a person being in hospital who could not be released unless they went into a nursing home or into a home-care situation. All that has to be arranged beforehand with the social worker dealing with the patient and it takes a period of time for the person to be released as they go to a step-down facility and from there to the home-care situation. It is a matter of linking all that together. As was mentioned, we need to ask what are the outcomes and to work back from that and say what is needed to work around it.

Another major problem will be the issue of consultants and other groups that have a vested interest in private health insurance. We as a committee have to present a model that people buy into and say that is the type of health service that we need and want and then we would move people into that. That will be the big task for us. Then there is the follow-up to that as regards the amount of money needed to pay for it. I would like to get the views of the witnesses on that.

Deputy Billy Kelleher: I have a few points and observations. Reference was made to the National Treatment Purchase Fund being a symptom of a malaise in the public health system and that it is an expensive way of doing its business. I do not know whether that is the case, because we do not know how much it costs, for example, to do a colonoscopy in the public system. How much does every individual procedure and diagnostic cost? I do not think we can compare until we have an analysis of the costs for these treatments in the public health system *vis-à-vis* the cost in the private health system.

The other issue about private health insurance is that while it only contributes 9% to the

public health system in terms of income, it contributes much more by the fact that those with private health insurance are not depending on the public health system. We have to keep things in perspective if we are to reach a conclusion. How many people are treated in the private health system who would otherwise be in the public health system if they did not have private health insurance? There is no doubt that if the public health system is under pressure as it is, carrying out all those additional treatments and diagnostics in the public health system would probably cause it to collapse.

The challenge we have to face is how, over a period of time, we can get to a situation where we can extrapolate the interconnectedness of the two systems so that we have a stand-alone public health system. The success of a public health system would be the fact that people would feel no need for private health insurance. The UK has the National Health Service and I detect a slow, incremental increase in private health insurance there over the last number of years because of the pressures the system is under. In a taxation-based model, the public health system is dependent on the public purse. When there is a squeeze, the whole thing comes under huge pressure. We will have to look at how we can ensure a certain level of ring-fencing in critical areas over a period of time.

In terms of a public health system and GPs, we all talk about primary care and we have a primary care strategy. Ms Loughnane spoke about 1988. Rory O'Hanlon was appointed Minister in 1988 and at the time he spoke about primary care being the bulwark for developing our health care system. This was in 1988. We are a long way away in terms of years, but not in terms of progress. The key issue in all of that is GP-led services in the community. What are the views of the witnesses on GPs being employed directly by the public health system, as opposed to the contractual arrangement we have? Due to the difficulties we have in attracting GPs into particular areas, there is going to be a certain amount of cherry-picking. It is a proven fact that in key areas where there are bigger socioeconomic problems there are also poorer health outcomes. That is where we need more GPs, not fewer. Regarding employment and contracts, where do the witnesses see the role of GPs being directly employed by the HSE?

Chairman: Does Deputy Harty have a point to make?

Deputy Michael Harty: There is a move now to provide universal access to free GP care. That does not necessarily mean universal access to primary care. There are three or four different types of medical cards now, all of which give people free access to their GP, but they will end up paying for their drugs and may not have access to other services like nursing, physiotherapy and dental services. There is a broad range in regard to the description of primary care.

In respect of salaried GPs, moves are being made in the inner city, where a group called Safetynet is providing GP services. It is actually a GP training scheme, where GPs are hand-picked to train in the inner city. They will work in the inner city, in areas where there might be one GP for every 2,500 people, as opposed to one for every 1,600. These are areas where one can innovate and can handpick GPs who want to work there. In the same way, there are GPs who want to work in a rural area. There need to be supports for all those types of GPs and general practices.

The move to free GP care is not exactly what it says on the tin. Yes, one gets to see one's GP for free, but there are restrictions.

Chairman: There is a commitment in the programme for Government to introduce the practice of salaried GPs, which is new. It is a welcome commitment, because it has traditionally

been resisted by GPs themselves. That is a good development.

Ms Cliona Loughnane: Again, I might just go through a few questions and then I will pass some on to others.

Deputy Kelleher spoke about the 9%. Not all private care is being provided in private locations and by private operators. It is about the mixing of the two. Often people are getting access to diagnostics through their private health insurance and then they are getting onto a waiting list to which other public patients who are waiting for diagnostics are not gaining access. It is more complicated than in other countries, where private insurance entitles one to private care in a private location. It is important for us to try to figure out how we can address that issue.

In terms of making the public health system more attractive, Mr. Gordon will talk to us about Deputy Kelly's question on what we are talking about when we refer to universal care. In terms of making it more attractive, there is the ten-year vision, but there is also the question of how we maintain the system as we work towards the that vision. I wonder whether there is an opportunity for this committee to make some recommendations about that. There are issues around maintaining the health budget and getting it back to where it was in the 2008 period. There are certain recommendations like that regarding a real focus on certain waiting lists within the public system, for example. Again, as we are so interested in patient outcome and patient quality of care, resourcing of the regulation within the system is something that will need to happen. As has been pointed out, we need to recommend resourcing of primary care. There has been an agreement in respect of primary care for a long time, but the resources have not been going that way. In terms of the committee's work, there might be the potential to make some kind of stopgap recommendations as well as the vision recommendations. I was going to make the point Deputy Shortall made that we may be about to see salaried GPs in the system for the first time. It seems to make a lot of sense to have salaried GPs. In other systems where there are salaried GPs, those GPs can be incentivised and involved in health and well-being. It makes more sense within a system such as that. It seems to have many potential benefits.

There has been some conversation about the NHS. I agree there have been many changes to the NHS since it was established in 1948. The Health Reform Alliance is not saying that what Ireland needs is an Irish NHS. It was just being used as an example of where a vision was articulated and actually came to fruition. One thing that can be said about the NHS, no matter what changes have happened, is that there is still a commitment to universal access to care that is free at the point of access. That is what we are talking about. As Mr. Gordon will say, we have to ask what the care we are talking about is. The NHS can be commended for that at least.

If one looks at Irish patients in the Republic compared to their counterparts in Northern Ireland, one can see the difference between having access to that kind of care free at the point of access and not having it. There was a study in 2007 which looked at people who were ill but who did not go to their GPs. In Ireland, 20% of patients said they had been ill in the previous year but had not gone to their GPs, whereas in Northern Ireland the figure was less than 2%. This just shows that where care is free at the point of access, particularly that kind of lower-level care, which is the care we really want people to be able to access to stop them getting to the high level care, it does make a difference. The mention of the NHS is illustrative rather than anything more than that.

Mr. Paul Gordon: On Deputy Kelly's point, in terms of formulating a plan for progression to universal health care, we need to look at who will be covered, who is already covered, who needs to be covered and whether there is an expansion in that. We also need to consider

what services are already covered, the quality of these services and what else will fall into that category. Finally, we need to look at what out-of-pocket payment costs will remain and how far that will extend. With that there is a need to acknowledge that it is not just about ensuring a package of health services but also ensuring a progressive expansion of those services when funding is available. The World Health Organization's guidelines on universal health care, while similar in wording to our Health Act 1970, are a little broader and less conditional. There is also a need to protect those at greatest risk. For example, in the six or seven years following the economic downturn, people were paying an extra €100 a year per person on medical care and prescriptions. Out-of-pocket payments rose by approximately €600 million between 2008 and 2014. There are people who face what are described as catastrophic out-of-pocket payments, which means they forego regular staple goods or services to pay for medication. We know, as do Deputies from individuals coming to their constituency offices, that people face a decision between paying a prescription charge or buying food for themselves or their families.

From our perspective, there needs to be a continuum of care. This is a multifaceted structure, which involves health promotion, disease prevention, diagnosis, treatment, palliative care and an integrated social care model.

Deputy Alan Kelly: Will the group document what it feels this to be and send it on to us?

Ms Cliona Loughnane: With universal health insurance, an attempt was made to develop a health care basket. This is one way to define what one wants from a universal system in the context of what and who will be covered. One approach the committee could take would be to examine what would be included in a health care basket. This has some benefits. It could consider how long people would be covered for rehabilitation and what out of pocket payments, if any, would be made.

There are other ways to do it. The UK has clinical guidelines developed by NICE, which decides the clinical outcome that should be achieved and the health trust then decides whether it can provide a particular treatment based on whether it meets the clinical guidelines.

Chairman: Will Ms Loughnane explain NICE?

Ms Cliona Loughnane: It is the National Institute for Clinical Excellence. It is a group that develops the models of care for different diseases. For example, it has a clinical standard for heart failure. Based on what it states should be achieved for patients with heart failure, those responsible for the budget in the NHS can decide whether these services are covered.

As discussed, the health care needs of a people change, based on the population and medical developments. If a health basket were established it would need to be updated on a regular basis. The Netherlands, which has a health basket system, has an annual consultation to discuss what should be removed or included. Clinicians are included in this process as are patient groups.

As indicated in our opening statement, we believe that definition of universality is very important and it could be achieved by the committee. We will send on material.

Dr. Marita O'Brien: Deputy Collins made some good points on the number of people who will require support, particularly in light of the demographics. In 2017 we will have 20,000 more people who are aged 65 and over. Some 2,500 are in the older age group of 85 years and over but our home help budget for older people, which was €211 million in 2008, has decreased to €192 million. We have 30% more people in the over 65 group. The funding has dropped

by 30% since 2008 but the population has increased by 30%, so one could say there is a 60% deficit.

Small interventions can make such a difference to people. A project on older people funded by the UK Department of Health found that every £1 spent on low-level interventions for older people gained an extra £1.20 for the acute care budget. Here we seem to crisis manage. It appears that when things come to a crisis, such as someone going to hospital, it is then that we start to look at what will happen to the person because he or she cannot go home and needs support. A total of 60% of the older people's budget goes on the nursing home support scheme and only 30% goes to services in the community. This shows the bias. The policy is to support people to age at home but the budget follows residential care. This is because the nursing home support scheme is legislatively underpinned and a statutory process is in place. It is very transparent and easy to apply for and, as has been stated, it is easier to move people from an acute hospital because the process is quite easy. It takes much longer for those seeking home care packages or home adaptations. We incentivise people to move to a more costly outcome than is needed.

I often notice the discourse about older people and, in the context of emergency departments, people wonder about nursing home beds. Very rarely do people wonder about community care for these people, although it has been mentioned over the past year. We seem to have a way of thinking and this needs to be changed. Perhaps that is something the committee could examine.

The care could be strength-based rather than deficit-based in nature, and Ms Loughnane has referred to this. This means looking at people's strengths and how they can be supported at a lower level. Someone could be given home help for four or five hours, which people do not get at present. People may get home care packages but not home help in many areas.

Deputy Harty made an important point on innovation. We must be innovative. We cannot just think this is how we do things. We must think of different ways of doing things. We could examine the salaries of GPs who are in disadvantaged areas. They could be trained to work in such areas so they understand the wider circumstances. This type of localised approach would be much more cost-effective and generally more effective in the long term than having an overall blanket idea of how it has to be. These are interesting ways to look at simple ways of doing things rather than more complicated ways which cost more.

Chairman: Another factor is that there is a legal entitlement to the fair deal scheme but not to a home care package.

Dr. Marita O'Brien: Yes, and it is very transparent. Home-care packages vary in every part of the country and it is the same with medical cards. The Chairman made a very good point. In some areas people cannot get access to a public health nurse unless they have a medical card. People cannot apply for home help or get a home-care package unless they have a medical card. A GP visit card may entitle people to free access to GPs, but it entitles them to very little really.

Chairman: Dr. O'Brien made a point about the wide variation in the services and entitlements available. Has any research been done on the allocation of primary care staff, or health and social care staff generally, throughout the country?

Dr. Marita O'Brien: From research we carried out with the Alzheimer Society of Ireland and the Irish Association of Social Workers we know that in some areas the primary care group may have been allocated funding but it may not have social workers attached to the team. Some hospitals use the social work services funding for a discharge planner. There do not seem to

be any structures. Each primary care group does not seem to be funded in the same way. They do not have to have particular professionals or staff or to relate the staff to the demographics of the area. There does not seem to be any link to the demographic of a community or area in how funding is applied.

The allocation of funding for home-care packages is not based on demographics and is not ring-fenced, whereas the nursing home support scheme funding is ring-fenced and, therefore, its budget is known. In the first three months of this year too many home-care packages were given out. How can I say too many home-care packages were given out when that was the demand and people were assessed as needing them? It meant that in some parts of Ireland, including Dublin and Galway, no home-care packages have been available for the past two months.

Chairman: There are waiting lists for home-care packages in many areas.

Dr. Marita O'Brien: What happens then is that families are encouraged to look at nursing homes so that the elderly person in question can leave hospital. That person may not have needed to go to a nursing home if they had received a home-care package. The longer somebody stays in a hospital the more they lose functionality.

Deputy Alan Kelly: At some point it would be useful if we could zone in on the cost variation of home care packages versus nursing home stay versus acute stay because apart from the health issue, from a cost point of view the impacts are incredible. The more interventions we can make on the home care package side, effectively, the more funds we will have to go around other areas. The fact that people cannot see that drives me insane and that we are dealing with huge waiting lists throughout the country while people are held up in acute hospitals, holding up beds at up to €7,000 a week versus €550 a week for a home care package.

Chairman: Staying at home is usually the first choice of older people.

Deputy Alan Kelly: Absolutely.

Dr. Marita O'Brien: It is something like the National Purchase Treatment Fund. It is the same thinking in that people do not think that by providing the service within the care system that in the end that probably prevents escalating costs. Home help services have been reduced in most areas. Previously, a home help would assist someone who had personal care needs but some would also help them prepare a hot meal or help them with essential domestic tasks but they are not allowed to do that now. In many areas all one can get is personal care. As one social worker told us, we can wash the older person but we cannot feed them. Thirty minutes to help someone shower once a week does not make sense. It is done on certain days so on Monday and Wednesday they will get a shower. God help them if they need a shower on the days in between because they will not get it. Over Christmas the home helps are on two weeks holidays so the people do not get any help with showering. Simple tasks like that are not that costly when one thinks about it.

Chairman: Has Age Action done any research on the comparative costs of different models?

Dr. Marita O'Brien: In our pre-budget submission we look at the cost of home care packages but it is very difficult to get exact information on that. When home care packages were introduced in 2008, people were getting an average of 15 hours but now they get only eight hours even though the assessment-----

Deputy Alan Kelly: I have a brief question and we may be able to help Age Action with this. Why is it difficult to get the exact information? Perhaps we should help in that regard.

Dr. Marita O'Brien: Home care packages were originally set up to provide home care, physiotherapy, occupational therapy for different kinds of needs but, anecdotally, home care packages are now more about providing home care. Home help can be incorporated into home care packages. Home care packages seem to have more to do with home care now. I do not know why one cannot get the exact number of hours. We put in a question on that so we might get information.

Chairman: It might be worthwhile for us to commission a separate piece of work on resource allocation. If we take, say, the nine community health organisations in the country and see the population, age and deprivation profiles and then see what staff allocation is in place already we can make an assessment. My understanding is that there is a very wide variation, both in terms of general practitioners, physiotherapists, social workers and so on.

Deputy Alan Kelly: Yes, that would complement the work.

Dr. Marita O'Brien: That would complement the work, and it would also give the committee an idea of costs if it looked at the resource allocation. Deputy Kelleher asked how we know that the National Treatment Purchase Fund does not provide good value. That would be a good piece of work to follow up with because it would give the committee an overall perspective when it is examining costings and so on.

Deputy Alan Kelly: It would complement the work-----

Chairman: Yes.

Ms Cliona Loughnane: The ESRI is engaged in a project that is looking at unmet need across the country and mapping those against staffing. That project is potentially in its second year, so they may have preliminary findings.

Chairman: Okay.

Ms Cliona Loughnane: Samantha Smith is in charge of that project.

Chairman: Did Deputy Harty want to come in on that?

Deputy Michael Harty: On a point of innovation, there is a commitment in the programme for Government to build 80 primary care centres but what we need are primary care teams rather than primary care centres. A primary care centre is a building and it might be a new shiny one but it does not necessarily guarantee that people will get new shiny services. If we had properly resourced primary care teams comprising physiotherapists, speech therapists, public health nurses, community care, social workers, speech therapists and general practitioners, that would be far more important than having a primary care building. If the HSE is to build 80 primary care centres, it should rename them community care centres rather than primary care general practitioner centres. They tend to be built around a cohort of GPs coming into the centres to anchor the services. If a community care building was to be built, it would be far better if it was to supply diagnostic services. Diagnostic services could be taken out of the hospital and put into community care centres which would mean one would not have to travel up to 60 miles to get a scan or an X-ray. One could get those in one's community care catchment area.

Another point is that there is a huge problem in retention and recruitment of hospital staff,

community staff, GPs and nurses. There does not seem to be any joined up thinking in that we educate nurses, doctors and physiotherapists but they are then left floating in the wind, so to speak, at the whim of recruitment, which can be quite restrictive. For instance, many qualified GPs are leaving the country because the system is so poor. They are probably highly indebted if they have gone through graduate entry medical school. They probably borrowed up to €100,000, which is crippling debt. People say that we have educated these doctors and ask why we are letting them leave the country. They say surely they should be committing themselves to the health service of the country that educated them. There must be a complete review because we educate these people but we let them go. We do not fight to keep them in the country.

Chairman: We will look at that entire issue in September; it is a separate piece of work.

Dr. Marita O'Brien: The system does not encourage people to stay. People become demoralised working in such a system. If a public health nurse visits people who need a service, he or she has to say he or she cannot do anything for them. Public health nurses wonder why they visit people when they cannot provide them with what they need. People become demoralised because they are in a profession that helps people but they cannot access what they need for the people. The same applies to social workers. It is demoralising when a multidisciplinary team does an assessment. There is the cost of doing an assessment for a multidisciplinary team. If a person needs 21 hours, the team comes back with ten hours. Then somebody else from the community does an assessment and looks at the resources we have and how we can give this person the minimum and still give him or her something but comes back with ten hours. There is such wastage even in carrying out all these assessments when the person will not be given what he or she needs anyway. It is very entwined, as Deputy Kelleher said. One action causes the other; it is like a domino effect.

Mr. Paul Gordon: On Deputy Harty's point about community care buildings, it is something we considered in the recommendations in our report on access to diagnostics. It is certainly something that would reduce the burden on waiting lists. The NCCP has trialled a service linked to the community on the western seaboard and I can certainly pass on any information I might have about that.

Chairman: With regard to cancer care, the cancer programme seems to be one of the major successes. Tom Keane will hopefully come in to talk to us in September. What is the question there about pre-access to services? I get the impression that the cancer programme is more of a universal service but I may be wrong.

Mr. Paul Gordon: Yes. In terms of rapid access clinics, it is more a universal service. We moved away from a decentralised programme. We have made great strides in treatment in the past decade or 15 years.

Chairman: What about the private patients? Are they treated similarly?

Mr. Paul Gordon: They would be, yes.

Chairman: From the point of view of diagnostics, access to treatment and so on-----

Mr. Paul Gordon: In terms of diagnostics, there is huge divide. If we look at gynaecological cancers, for example, the difference in waiting times for ultrasounds is about seven days. The waiting time for MRI brain scans, which are particularly hard to come by in both systems, could be up to 480 days in the public system and perhaps 20 to 25 days in the private system. The waiting times for colonoscopies have risen about 129% in the last five years and it is prob-

ably slightly more than that now.

Chairman: Apart from diagnostics, that is obviously a critical area. In terms of access to treatment once there is a diagnosis, is there much of a divide?

Mr. Paul Gordon: No. Once one is in, it is a lot easier and there are clear pathways to treatment. It is easier for patients once they are past the diagnostic stage. The problem is with the waiting time where, if I am going in for a colonoscopy, I have to wait six months. Within the existing waiting lists at the end of last month, there were 5,036 people waiting over three months for a colonoscopy. Obviously, those referred for an urgent colonoscopy are seen within four weeks, but in the larger group waiting longer than three months there will certainly be someone who has a cancer and that may be at a more advanced stage than if it had been caught earlier or the person went through the private system. That is where the ability to pay comes in.

Deputy Joan Collins: Why is that? Is it staffing, machinery or access?

Mr. Paul Gordon: We do a lot of work on colonoscopy and there is huge demand. It has increased over the past few years. I cannot necessarily put my finger on a specific cause of the problem, but we have seen a huge increase in the past number of years. What is required in that field is greater referral pathways. HIQA produced specific guidelines in relation to colonoscopy for general practitioners at the end of 2014. They were issued to consultants, but I do not think they have been followed up on with GPs or that any additional training has been provided. As I mentioned earlier, there are problems with referrals between hospital groups. What we would really like for patients is the right intervention for the right person at the right time. One could have a GP for whom the referral path and guidelines are not there. If someone presents with abdominal pain, he or she will send that patient on for a colonoscopy. However, there might be a better intervention available. That increases the pressure on the system. If GPs have people coming in repeatedly with similar symptoms and waiting longer and longer, he or she may refer a patient as an urgent case whereas that may not necessarily be what is required. That burden is there. It is very difficult for a consultant then to say that the person does not need that intervention, because it could cause huge difficulties down the line. Unfortunately, it is a cyclical thing.

Chairman: The witnesses spoke earlier about 80% of hospital activity relating to chronic illness. There are chronic disease management programmes set out for primary care. Why are they not being implemented? Perhaps, I should ask Deputy Harty about that. If there are best practice programmes in place that will achieve better health outcomes and better value for money, why are we not implementing them?

Ms Cliona Loughnane: Partly, it is to do with budgets. If one looks at the budget that goes to primary care as opposed to the budget that goes to acute hospitals, one sees that we are completely prioritising the latter field. As Dr. O'Brien was saying, there are knock-on effects on all these different areas. When one has very high waiting lists, it is understandable that a lot of budget goes to the acute sector. However, while we have talked about the development of primary care, the budget has not really shifted in that direction as yet. As we have discussed, there are serious staffing issues at primary care level. The other thing, as Dr. O'Brien pointed out, is that in certain areas it is not clear who is entitled to or eligible for these services. We have spoken a great deal about moving care out into the community, but we have not achieved it. Budget and staffing have a lot to do with it.

Dr. Marita O'Brien: That could be one of the first things to look at in the context of universality. Who is entitled to chronic disease management? Is it a question of one's means?

That is a very simple thing to think about in the sense of what we mean by “universality”. If we want people with chronic diseases to manage their diseases, keep well and stay out of acute hospitals, there cannot be too much of a cost involved for them. As such, the cost impact of people failing to participate, if it is an individual thing, must be looked at. As Ms Loughnane said, it is more to do with capacity, but in thinking about universality, the question is whether we want everybody with a chronic disease to manage to go to their doctor to have the proper tests for COPD or cardiac issues and for stroke prevention care. If somebody has had a stroke, how do we prevent another one? If there is going to be a cost to the individual, is he or she going to continue to have tests? Universality can benefit people so much by allowing them to access those things when they need them in a timely way rather than to put them off for years.

Chairman: The hardest part is to switch the funding from the acute sector to primary and community care. On the phasing in of universal access to care, do the witnesses have any general advice? They were talking about it appearing to be Government policy to extend free GP care across the population. That is only one element. Entitlement to other health professionals, home help, physiotherapy and occupational therapy and access to subsidised medication are others. Do the witnesses have a view on the phasing in of that and the most appropriate way to proceed?

Dr. Marita O’Brien: For a couple of years, the budgets will have to be increased for the overlap because one cannot suddenly stop funding acute care. If one did, one would then end up in further crisis. With the health and social care integration programme, the HSE has developed a really good model of integrated care for older people in particular. One cannot suddenly stop funding nursing homes. We did that before and had a crisis of a 12 to 20 week wait for nursing home beds. One cannot just take funding from one area and give it to another. Increased funding will have to happen. As a society, we have to ask how important it is for our population. In all of our reports, it states that the health of our population is our most valued commodity. As a preliminary matter, funding will have to be increased but it will have to be done in a targeted way. Particular targets will have to be set out so that such a thing is achieved at primary care level with such funding. Gradually, the savings should start to come into effect in the acute and other care areas. Those savings could be used to fund the continued move to primary care. Over a certain number of years, there will have to be increased funding for health which is targeted at placing services back in the community.

Chairman: Is the way to go to implement the chronic disease management programmes or should it be done on an age cohort basis?

Dr. Marita O’Brien: Equity is not based on age alone. The medical card review group found that one could not prioritise illnesses either. Chronic disease management could be the place to start or it could be a matter of starting at the level of the smaller services and interventions. Start to do the small stuff first, which should give results that facilitate the implementation of bigger things. That is what they found in the UK anyway. There was a 30% or 40% fall in bed days just by introducing small interventions. I am not sure what funding was distributed nationally, but the savings were quite good.

Chairman: I thank the witnesses for giving up their time to come in. It has been very worthwhile.

Deputy Mick Barry: Can the information on the question of savings and the cost benefits of a taxpayer-based system be forwarded to everybody?

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Ms Cliona Loughnane: We will send it to the clerk.

Chairman: That is fine. We will then circulate it. The witnesses also mentioned that the ESRI is doing work at the moment. We will request that from the ESRI. This has been a very worthwhile session and we appreciate the witnesses' time. I ask the members to hold on while we conduct some private business before we adjourn.

The select committee went into private session at 10.40 a.m. and adjourned at 10.55 a.m. *sine die*.