DÁIL ÉIREANN

COISTE UM CHÚRAM SLÁINTE SA TODHCHAÍ

COMMITTEE ON THE FUTURE OF HEALTHCARE

Dé Céadaoin, 25 Eanáir 2017

Wednesday, 25 January 2017

The Joint Committee met at 9 a.m.

MEMBERS PRESENT:

Deputy Mick Barry,	Deputy Michael Harty,
Deputy John Brassil,	Deputy Billy Kelleher,
Deputy James Browne,	Deputy Hildegarde Naughton,
Deputy Pat Buckley,	Deputy Kate O'Connell,
Deputy Joan Collins,	Deputy Louise O'Reilly.
Deputy Bernard J. Durkan,	

DEPUTY RÓISÍN SHORTALL IN THE CHAIR.

The select committee met in private session until 9.15 a.m.

Health Service Reform: Dr. Brian Turner

Chairman: I remind everybody in the room to ensure their mobile phones are either turned off or on aeroplane mode so there is no interference with the recording and broadcasting system. I welcome our witness and those watching our proceedings, as well as committee members. In this morning's session we will receive evidence from Dr. Brian Turner, with a focus on the goal of a universal, single-tier health system. I warmly welcome Dr. Turner from the department of economics at Cork University Business School at University College, Cork. I thank him for attending the meeting at short notice and facilitating the committee. Dr. Turner lectures in health economics and health insurance issues and previously worked in the Health Insurance Authority. His research has been published nationally and internationally. His submission to the Committee on the Future of Healthcare has already been circulated to members and I thank him for it.

I will begin with some formalities and by advising our witness on the matter of privilege. 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. If they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a 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 they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against a person or persons 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 House or an official either by name or in such a way as to make him or her identifiable.

I invite Dr. Turner to make an opening statement.

Dr. Brian Turner: I apologise in advance if my throat sounds hoarse. I have been doing a little first-hand research of the Irish health system over the past couple of weeks and I hope I will get through this okay.

I begin by sincerely thanking the committee for the invitation to address it today. It is a great honour and a privilege to be asked to contribute to the very important work that the committee is undertaking and I hope my appearance today will be of some assistance in this regard. It is worth acknowledging that despite its flaws, the Irish health system has its good points and these should not be forgotten. Patients are generally happy with the treatment they receive in hospitals, although access can be a problem. Most people can receive a same-day or next-day appointment with a GP, something that is not always the case in other countries. Life expectancy and self-assessed health status are both above average in Ireland. Our health system is getting some things right and those areas that are working well need to be built on while addressing the shortcomings in other areas.

When examining the workings of a health system, economists sometimes use what is known as the health care triangle, which is illustrated in figure 1 in the presentation. Unlike most goods and services, health care often, although not always, involves a third party purchaser, which pools contributions and purchases care on behalf of contributors. Citizens provide funding to

the third party purchasers, which allocate funds to providers, which deliver care to those who need it. Using third party purchasers involves an element of social solidarity, as a large group of people pay into the pool while not all will require treatment. This system thereby reduces the risk that would be faced by citizens if they were obliged to pay the full cost of all of their care themselves.

In Ireland, it could be argued that we have two health care triangles operating alongside each other. In the public health system all citizens pay taxation that is pooled by the Government and allocated, via the HSE, to providers who deliver care to public patients. Simultaneously, we have a private system where nearly half the population pays premiums to private health insurers which pool those funds and allocate them to providers, which deliver care to private patients. There is also a system of direct, out-of-pocket payments, which are paid directly by some citizens to providers for care. Examples would include payments to GPs by patients who do not hold medical cards or GP-only medical cards, and payments to pharmacies for prescription medication up to the drug payment scheme threshold by patients who do not hold medical cards. One source of difficulty in the Irish system stems from the fact that public and private patients are often treated by the same providers, while the allocation mechanisms of the public and private funds differ. Central Statistics Office, CSO, figures from 2010 show that of those patients with private health insurance who had been hospitalised as inpatients in the previous 12 months, over 60% were treated in public hospitals. A significant proportion of consultants, meanwhile, have contracts that allow for a mixture of public and private practice. For hospital treatment, public hospitals and consultants are paid on a fixed basis, with some adjustment for case mix for hospitals, for treating public patients, while they are paid on a fee-for-service basis for treating private patients. Treating more public patients therefore does not yield more income, whereas treating additional private patients does, thereby creating an incentive to treat more private patients. I am aware that moves are under way to roll out a money-follows-the-patient system in public hospitals, but depending on the relative reimbursement rates for public and private patients, there may still be an incentive to favour private patients even under this new system. Although Ireland is not unusual in having a mixture of public and private funding and delivery mechanisms, Ireland is unusual in the degree of overlap between them. This overlap does not all go in one direction either, as some public patients have been treated in private hospitals under the National Treatment Purchase Fund. On the funding side, the State partially subsidises the purchase of private health insurance, the most obvious subsidy being the tax relief at source granted on private health insurance premiums although this was capped in 2013. Meanwhile, public hospitals receive hundreds of millions of euro per year from private health insurers for the treatment of privately insured patients. I believe that one focus of the committee's plan for the next ten years should be to try to disentangle this overlap between public and private funding and delivery. The committee's terms of reference refer to the need to establish a universal single-tier service where patients are treated on the basis of health need rather than on ability to pay. Although this is a noble aspiration, I do not believe that an entirely single-tier system for all health services is achievable, given that the private health insurance market and the private hospital system are both well established. Rather than try to eliminate these, consideration should be given to what role they will play in the Irish health system into the future. Bearing this in mind, the concept of a universal single-tier service needs to be defined as the destination will determine the route to get there. That being said, I believe that it is important to try to reduce the degree to which public patients seeking treatment in public hospitals are impacted by the treatment of private patients in these same hospitals. One possible way of doing this would be to move to a situation where public hospitals are used to treat public patients only, bearing in mind that those with private health insurance do not forsake their right to be treated

as public patients. It may be considered acceptable for those with private health insurance to use that insurance to pay for better accommodation, but not to receive faster access. This would, of course, require contract renegotiations with consultants and additional State funding for public hospitals. If access issues facing public patients in public hospitals were addressed it would remove one of the main drivers of demand for private health insurance, thereby naturally reducing the two-tier nature of the hospital system.

It should be borne in mind that, while the Irish health system is often referred to as a two-tier system, where private patients are better off in terms of receiving services than public patients, it is actually more nuanced than that. While it may be the case that private patients are better off in terms of hospital treatment, the opposite is often true at primary care level, where services are provided free at the point of use to those with medical cards and with GP-only medical cards, while private patients - that is, those who are not in possession of a medical card or a GP-only medical card - must pay significant out-of-pocket charges for services. In this case, those who have to pay privately may be reluctant to access services because of cost and research has shown this to be the case. One paper, by Dermot O'Reilly and others, published in 2007, showed that over 26% of people without medical cards had put off going to see a GP on cost grounds in the previous 12 months, compared with fewer than 5% of those with medical cards. While some of these people may get by without seeing a GP, undoubtedly in some cases the delay in seeing a GP will contribute to the illness getting worse before they eventually have a consultation, which may result in some of them requiring hospitalisation, which is a far more expensive form of treatment. The removal, or at least reduction, of the financial barrier to accessing GP services should be another priority of the ten-year plan. Although moves have already been made to do this, with the roll-out of universal entitlement to GP-only medical cards for the over-70s and children under six, I believe that priority should now be given to those on lower incomes rather than those in certain age brackets. GP-only medical cards do not give increased access to GPs *per se*, but rather they remove the financial barrier to accessing GP services. This financial barrier is more acute for those on lower incomes, for whom the cost of GP visit at an average of over €50, represents a significant proportion of their weekly income. Therefore, I believe that serious consideration should be given to raising the income thresholds for GP-only medical cards. While this might be more administratively cumbersome than rolling out eligibility by age group, I believe that it would be more beneficial to those who struggle to afford GP services.

It should also be remembered that it is not just GP services that pose financial challenges for people. For those without medical cards, the drug payment scheme threshold, which must be met before the State funds prescription charges, is €144 per month, which represents a significant proportion of many households' income. Furthermore, this threshold has increased since the onset of the economic downturn, as have a number of other charges as shown in table 1 of the presentation, while prescription charges were also introduced in 2010 for those with medical cards, and these have also been increased since then. These increases in user charges were introduced as a result of a shrinking public budget available for health services, and they, combined with significant increases in private health insurance premiums over the same period, led to an increase in the proportion of total health spending coming from private sources, from 21% in 2008 to 31% in 2014. As private sources of funding, including private health insurance premiums and user charges are regressive sources of funding, meaning that those on lower incomes pay a higher proportion of their income, while public sources, including taxation, are progressive sources, meaning that those on higher incomes pay a higher proportion of their income, the shift from public to private sources has adverse implications for equity in the system.

I spoke earlier about the health care triangle. Citizens are the ones who fund health services.

This is the case irrespective of the funding mechanism used. Therefore, the debate in terms of cost shifting is not so much about who pays but rather about how the burden of payment is spread. Ideally this should be spread in as equitable a way as possible. This raises the issue of how to fund public health services. The main options used around Europe are taxation, which is the main source of funding in Ireland, and social health insurance. The latter has also been proposed for Ireland. I believe, however, that rather than changing the funding mechanism the focus should instead be on the allocation of funds and delivery of health services. One key focus should be any incentives that exist within the system or that are created by any redesign of the system.

It should also be borne in mind that significant improvements in the public health system in Ireland will entail significant costs. It needs to be acknowledged that the Irish system is under-resourced in a number of areas. According to the Organisation for Economic Co-operation and Development, OECD, figures, we have 2.7 doctors per 1,000 population, compared with an OECD average of 3.3 and within our figures we have a lower than average proportion of specialists. The OECD figures also show that we have 2.8 hospital beds per 1,000 population, compared with an OECD average of 4.8. If we were to try to reach the OECD average figures, we would require 2,800 additional doctors and over 9,000 additional hospital beds. Although we currently have a younger than average population, which may mitigate these numbers to a degree, Ireland's population is growing and ageing, which will affect the demand for health services. CSO projections suggest that our population will increase from 4.6 million in 2011 to somewhere between 5.0 and 6.7 million by 2046. Furthermore, the proportion of the population aged over-65 is projected to rise from 11.6% in 2011 to between 21.6% and 27.9% by 2046. The proportion of the population aged over-80 is projected to rise from 2.8% to between 7.2% and 9.4% over the same time period. Evidence shows that those in older age groups have, on average, a higher utilisation of health services than those in younger age groups. The ageing of the population, coupled with an increasing incidence of chronic illness, is engaging health policy makers in many countries, not just Ireland. As demonstrated by the resource figures in table 1 of the presentation, our system is perhaps less well equipped to face these challenges. The Irish health system never fully recovered from the cutbacks in the late 1980s and early 1990s, and this is affecting our ability to meet the health needs of our current population, let alone provide for the anticipated increase in demand resulting from our growing and ageing population. While one major area of focus is trying to keep people out of hospitals and ensure that they are treated instead at primary care level, and this is a worthwhile focus, it will require significant investment in primary care in order to ensure that resources are in place to fulfil this ambition. Significant investment will also be needed in our hospital system, which still has fewer beds than it did in 1980, despite a significant increase and ageing of the population over that time. While it is true to say that it is not all about money, it is also the case that what we want to achieve will not be achievable without significant additional funding. I hope that this opening statement provides some food for thought for the committee. I thank the committee for the invitation to appear before it, and I wish it every success in its important work.

Chairman: I thank Dr. Turner. I will open the debate to members and I propose to take members in groups of three. Will Dr. Turner note the question and deal with them in groups?

I call Deputy Naughton.

Deputy Hildegarde Naughton: I thank Dr. Turner for coming before us this morning. I am particularly interested in his comments that the health service is under-resouced in terms of consultant numbers and the number of hospital beds per 1,000 of population. Dr. Turner gave

the OECD average bed capacity per 1,000 of population as 4.85 compared with 2.8 in Ireland. The Department of Health is carrying out a bed capacity review. Is there any other metric, other than the OECD figure, to identifying our bed capacity needs?

Does Dr. Turner hold the view that the Department of Health should commission an independent review of bed capacity? In his opening statement he referred to the fact that the private hospital sector is deeply embedded in our health system and that it would not be possible to do without some form of private health service. Will he expand on that point as it will form a key part of the discussions that will feed into our report?

I would be interested to hear Dr. Turner share his top priority actions that would have a great impact on the health service.

Deputy Louise O'Reilly: I thank Dr. Turner for his presentation. In the course of his presentation Dr. Turner states that he does not believe an entirely single-tier system for all health services is achievable but I would be interested to learn if he thinks we should aspire to a single-tier system, if nothing else. I understand that we are the only country, bar the US, that does not have a single-tier system. Will he explain his views on whether it would be completely futile to have a single-tier system or whether we should aspire to an universal health system?

In the course of his presentation, he referred to the incentivisation to treat private patients instead of public patients. With regard to the dismantling of that incentive, were we to go down the road of eliminating the subsidy that is available to those who purchase private health insurance, that could generate in the region of €350 million to €355 million, which is a fairly conservative estimate. What is his view of the impact of the possible elimination of that subsidy on the perverse incentive to treat private patients and the possibility of reinvestment of that money in the health service?

Chairman: I thank Deputy O'Reilly and I now call Deputy Barry.

Deputy Mick Barry: I thank Dr. Turner for his interesting presentation. I want to track back to a point he raised at the outset. Please correct me if I am wrong, but it seemed to me that Dr. Turner's argument was that because of the embedded private health insurers and private hospitals within the health services, the concept of a single-tier health service was not achievable and that in his view, a more realistic goal was to try to moderate the character of the two-tier health service we have? Let me flip the argument on its head as our mandate is to deliver single-tier health care. Is Dr. Turner saying that a single-tier health care service could only be delivered if we were to effectively nationalise the private hospitals and bypass the private insurers by developing a tax base system which provides health care free at the point of use? Obviously that would involve a far greater level of upheaval and change and that is a matter to be debated by the committee. Will he clarify whether he is he saying that if one wants to achieve the goal of a single-tier health care system, one would need to take steps of that kind?

Chairman: I think it is important to clarify a point. Our mandate, as Deputy Barry states, is to draw up a strategy for the introduction of a universal single-tier health service. That does not necessarily preclude any private health sector but what it does mean is that any State subsidy to private services would cease. We know that in the United Kingdom, which has the NHS, 10% to 15% of people have private health insurance but there is no State subsidy of the small private sector health service. That is the key point.

Will Dr. Turner respond to those questions?

Dr. Brian Turner: There is quite a bit of content but there is an overlap between some of the questions. In terms of the under-resourcing of the system, we do not necessarily need to reach the OECD bed capacity average as we have a younger than average population, but I was putting the figure out there to give members a sense of the scale of the challenge facing the Irish system. We need to increase the resources for both hospital bed capacity and to increase the number of doctors.

Ideally, the Department of Health review of capacity should be independent but the last independent review of which I am aware was undertaken in 2007. I suspect that bed numbers have not changed radically since then, and if memory serves, our bed capacity at that point was approximately 15,000 beds. That compares with 18,000 hospital beds in service in 1980. I acknowledge we are trying to move people out of hospitals and the trend is to move from inpatient to day case procedures, which is reducing the need for beds. That reduction of bed numbers from 1980 to the present day, when the population has increased by one third and an increase of two thirds in the number of people over 65 years who are disproportionately likely to have a need for hospital services, puts a significant a significant strain on the system.

As the OECD figures are the figures with which I am most familiar, they are the ones I tend to use. One may ask how did the OECD arrive at its figures? I presume it got them from the HSE and the Independent Hospitals Association.

In terms of private hospitals, I was possibly being a little provocative by saying it might not be feasible to have an entirely single-tier health system. What I was trying to do was stimulate a debate on what we mean by a single-tier health system. It is very hard to think of any country, certainly in Europe, that has an entirely single-tier system for all health services. There is usually a mixture of public and private funding and delivery. Where we need to focus is on trying, as the Chair suggested, to separate out the two systems. For example in the UK, the take up of private health insurance is about 11% to 12%. I remember reading a figure a few years ago that only 1% of the treatment of patients in NHS hospitals was of private patients, which is a very different picture from the one in Ireland.

One other reason I suggest the embedded nature of the private hospital sector and the private insurance sector in the Irish health service will affect the attempts to move to a single-tier health system pertains to the judgment Mr. Justice McKechnie delivered in 2006 in the High Court case that BUPA Ireland took against the State in 2003 on the risk equalisation scheme. One argument BUPA Ireland was making that having set up in Ireland, it had a right to continue its business in the State. I am not a legal expert. As a non-cognate, my interpretation of what Mr. Justice McKechnie said was it is not beyond the bounds of possibility that the insurance sector could be taken out of the picture in the national interest but an argument would have to be put forward to do so. Given that no system in Europe, that I am aware of, has gone from a two-tier system to removing the private sector, it would be difficult to make an argument for same. I suspect that if one tried to do so one would face significant legal challenges from the insurers and the private hospital operators that are highly dependent on insurers. In addition, depending on whether the private system is completely removed or incorporated into the public system, one could be looking at significant job losses. There are 8,000 jobs in the private hospital sector. I am not sure how many jobs are in the insurance sector but I suspect it is about 2,000 jobs. That means 10,000 jobs rely on the private sector. Care needs to be taken when deciding whether to eliminate the private system or incorporate it into the public system.

We must define what we mean by a universal single-tier health system and whether it is public or private. A universal single-tier public health system is achievable. I am not sure that

a universal single-tier health system for everything is achievable but it certainly is not in a ten-year timeframe. Having said that, if we are here in ten years time debating health matters I will be delighted that my assertion has been proved wrong.

I have been asked what one thing I would prioritise, which is a tricky question to answer. Extra funding at primary and secondary care levels is the short answer. We are moving towards increasing our reliance on primary care. Before we can move people out of hospitals we must ensure that resources are available in the primary care sector to deal with them effectively. I would say extra funding is my number one priority if someone put a gun to my head for an answer.

Deputy O'Reilly asked about the suitability of a single-tier system. I have talked a little about an entirely single-tier system. Every European market has a private health insurance market and how it operates can differ. In some cases, private health insurance can be substituted for a statutory system. In other cases, it can be complementary so covers things that are not covered or partially covered by the public system. In Ireland we have a largely supplementary system that gives people additional benefits such as faster access, a greater choice of provider or superior accommodation. The nature of the health insurance system is part of the problem. Interestingly, when the current health insurance market was established in 1957 following the passing of the Voluntary Health Insurance Act, the top 15% of earners did not have access entitlements to public hospitals. The scheme was designed to give them the option of paying for their care if they fell ill without facing significant hospital bills. The scheme was not limited to the top 15% of earners. One can argue that it was a substituted system for the top 15% of earners but a supplementary system for anyone else who decided to avail of the scheme.

The access entitlements to the public hospitals system were increased over time with hospital accommodation taken care of in 1979 and treatment by hospital consultants taken care of in 1991. At that stage the nature of the system had changed greatly but no consideration was given to whether the health insurance system was still needed. Very shortly afterwards in 1992 the European Third Non-Life Insurance Directive was introduced thus ensuring that all member states opened all of the non-life insurance markets to competition. Once that happened it became much more difficult to consider the role of the private health insurance system. We must take this aspect into account when figuring out what we want to achieve. A single-tier public hospital system is achievable. A single-tier primary care system is achievable. I do not know whether it is possible to eliminate the private hospital and private insurance markets.

Chairman: I wish to clarify that the committee has not made such a proposal.

Dr. Brian Turner: I have not suggested that the committee proposes to do so.

Chairman: One cannot prevent a person in any country who has sufficient means from buying top of the range accommodation and immediate access to health care.

Dr. Brian Turner: Yes.

Chairman: Dr. Turner has mentioned case law. The committee does not propose such a situation. People have a right to buy services if they wish. Dr. Turner referred to the State funding of health services.

Dr. Brian Turner: Yes.

Chairman: It is important to make that clarification.

Dr. Brian Turner: I thank the Chairman.

Deputy Louise O'Reilly: Dr. Turner has outlined the embedded nature of privatisation and private health care in the health service. As the Chairman has correctly pointed out, we cannot prevent people from purchasing private health insurance. The biggest single incentive to not purchase private health insurance is getting what one needs from the public system. Should we not aspire to that situation, notwithstanding the constraints? Should we copy what was done with the NHS bill in Britain? On that occasion people sought what they wanted and made choices. Is that not preferable to highlighting all of the reasons we might not get there or get there quickly?

Dr. Brian Turner: Certainly, as an aspiration, I do not disagree. We should temper our demands by realising what can be achieved. As has been said, the best way of reducing the two-tier nature of the system would be to have a public health care system in which people have confidence. Surveys repeatedly show that one of the main drivers of demand for private health insurance is people's lack of confidence in the public health system-----

Deputy Louise O'Reilly: Yes.

Dr. Brian Turner: -----and access to the public system.

Chairman: Does Deputy Barry seek a clarification?

Deputy Mick Barry: Yes. I will preface my supplementary question by stating the following. In terms of the conclusions reached by the committee on how to deliver single-tier health care, my position is that noting is ruled in and nothing is ruled out. Evidence has been given to this committee that following the example of Canada would be a powerful assistance in achieving a single-tier health system. Canada has taken steps to tackle private health insurance by providing a credible tax based alternative to people. I will not rule anything in or out in terms of the committee's proposal.

I shall ask my supplementary question. A contradiction exists because private hospitals and private health insurers are, using Dr. Turner's phrase, embedded in the system. He mentioned the interesting scenario of single-tier public hospital care and single-tier primary health services without subsidising the private sector. If one did that with any real measure of success more people, progressively and incrementally, would be brought into the public health care system and, progressively, fewer people would use the private health care system. At a certain point issues would arise with the 8,000 jobs in the private hospitals system and the 2,000 jobs in the private insurance system. Problems could be averted by nationalisation because the sectors would be integrated on a different basis and jobs would be protected. One cannot have a big public health care sector used by masses of people and a big private health care system used by masses of other people yet have anything approaching a single-tier health care system. The more successful the public system is the greater balance will be achieved. Would Dr. Turner not accept that that is the case?

Dr. Brian Turner: I would. That raises the question of what the natural level of demand for private health insurance is. If the public system and the private system were reasonably comparable in waiting times and services, how many people would choose to have private health insurance and open up the access to additional hospitals? I do not know the answer to that question. At the moment, there is so much treatment of private patients taking place in public hospitals that if that was taken out of public hospitals as a first step, there would be plenty to

keep the private hospital sector going. As the demand for private health insurance winds down, we are getting to a scenario of how much is sustainable. I do not have a simple answer to that.

Deputy Mick Barry: Thank you.

Dr. Brian Turner: Deputy O'Reilly asked a question about the incentivisation to treat private patients and the elimination of the subsidy. She mentioned €355 million. That is the latest figure from the Revenue Commissioners for 2014, which is down from about €450 million in 2013. The difference is largely accounted for by the rule of the bed designation. I have sent an e-mail to the Revenue Commissioners. There is possibly a small bit of the €355 million that is accounted for by historical adjustments to the interim measures prior to the risk equalisation scheme, but it will be close enough to the €350 million. If that incentive was eliminated, it would certainly be available to the public system. Having said that, if we removed the private patients from the public system, then we would have the additional cost of treating public patients in the beds that would be freed up by the private patients. Therefore, it would probably more than offset that figure, but there is certainly an offsetting figure there. I think that covers the questions asked.

Deputy Billy Kelleher: I welcome Dr. Turner. I declared to the committee last week that we commissioned Dr. Turner to independently evaluate universal health insurance as proposed by the previous Government and other funding models. That was independent, as opposed to Fianna Fáil policy. I wish to be very clear on that.

There are a few issues that have been consistently raised. There are also the ideological debates on the funding of health care and access to health care, but I wish to get back to the pragmatics of it. Dr. Turner said that we have a very intertwined public health system and private health system in this country due to the fact that many beds are used on a daily basis to treat private patients in public hospitals. If we are trying to get to a single-tier universal health care model, how would Dr. Turner propose to disentangle that dichotomy of private patients in public hospitals? Is there capacity enough in the private system for private patients to be treated there? In very complex cases in which the private system simply cannot treat the complexities of individuals, what sort of funding model could be put in place to ensure that the public health system is fully reimbursed?

There is the other issue of the disparity in access for diagnostics and treatment between public and private, which is always pointed out and rightly so. How could it be possible to have a single list of people in both public and private who are trying to access public hospitals, if the witness understands my meaning?

When we talk about health care and the public health system and say that the private system should be reduced or not depended on, we must remember that the vast majority of primary care is delivered through the private sector in terms of GPs. By and large, they are sole traders and operate independently, subject to the contract itself. Where does Dr. Turner see the role of GPs and the broader primary care system in the delivery of a universal primary care system? Does he see a need to expand salaried GPs? How would the witness bring that to a situation in which there would be an obligation on GPs to deliver a fully-funded universal primary care system?

How does the witness see the issue of tax relief for private health insurance? A view is sometimes put forward that people who retain private health insurance are somehow queue-jumping elitists. Of course, half of the population have private health care. They are subsidised to a certain extent by the fact that they get tax relief for their private health insurance. The *quid*

pro quo is that they are equally subsidising the State by the fact that they do not depend on the public health system for their health care. In the event of there being a universal health care system, then they would be dependent or could call on the State to ensure that it would provide health care for them. This is an area in which affordability is going to be a key issue. We cannot dismiss this as a committee if we are to move towards expanding the public health system to deliver a universal single-tier health system.

The witness spoke about additional GP numbers of 2,900 and additional beds of 9,000. While it is aspirational, how affordable would it be to expand capacity out in the short, medium or longer term? It would be a folly not to at least use the capacity of the private health care providers in the short and medium term to expand the capacity of the public health system. There is the National Treatment Purchase Fund, which I accept is a short and medium-term solution to overcrowding and waiting lists.

With regard to the recruitment of consultants and consultants' contracts, there seems to be a huge issue with incentivisation, where consultants are more incentivised to treat patients in the private health system rather than the public health system. How does Dr. Turner see that issue being addressed if we are to disentangle the whole concept of public and private?

Deputy Bernard J. Durkan: I thank Dr. Turner for his submission. I apologise for being absent at the beginning due to parking difficulty. I have the submission in front of me. A consultant friend of mine has identified - according to himself, anyway - that medical economics is public enemy No. 1 in so far as the delivery of health services is concerned. He cites the extent to which medical economists have been in favour of the reduction of bed numbers and bed capacity over a number of years, resulting in what we see now. He cannot understand that. What is Dr. Turner's response to that?

What is Dr. Turner's response to the phrase we often hear that the health service has an insatiable appetite for money and that no matter how much money is thrown at it, it will absorb it, consume it and be back for more?

How does the witness address the comparison with other jurisdictions in order to achieve the bed levels that other OECD countries have? Recognising the cost involved, how does Dr. Turner feel other jurisdictions are doing in dealing with health services, given that a number of crises have emerged in a number of them in recent years and more are emerging? For instance, how does the witness view the health service in the Netherlands, which was very good a couple of years ago, but is not deemed to be so effective and efficient now? How does Dr. Turner respond to that?

I am sorry for the number of questions, Chairman. I will only contribute once. There was a suggestion referred to slightly by Deputy Kelleher that the private health sector feasts off the public health sector in terms of the resources available and that it advances at some cost to the public sector. How does the witness respond to that suggestion? A programme was done on RTE a couple of years ago which strongly suggested that. I would be interested in the comments of Dr. Turner on that.

This is my last point. If there are long waiting lists, which there are in this country and a number of others at the present time, it certainly points to a deficiency somewhere. Is it a lack of personnel, bed accommodation, management or expertise? What is the cause of it? For example, a consultant can only work a certain length of time per day. It is not a good idea to work for 18 hours if one is performing surgery. What is the optimum ratio of consultants per 1,000

population? At what level do we get the best performance?

Why is it necessary to have waiting lists? If someone has a list of people waiting, they have either been taking time out or there are too many people coming into the office. How do we marry demand to the available facilities?

Deputy Pat Buckley: I will be brief. In his opening statement, Dr. Turner mentioned the current funding model, but he also referred to a reallocation of that funding. Will he expand on what he meant by that? Where would he prioritise and reallocate the funding? Would a new bed capacity review be needed to get exactly what we need as an answer for where the system is failing?

Dr. Brian Turner: I will start with Deputy Kelleher's questions on the disentangling of private treatment in public hospitals, and whether the capacity exists in the private sector to treat complex conditions. Part of the disentangling of private treatment in public hospitals will require contract fee negotiation with consultants. I am aware that the last contract renegotiation took about seven or eight years, so that will not be easy. However, it should not stand in the way of trying to achieve a single-tier public hospital system.

There is some suggestion that the private hospital system has capacity at the moment, and certainly the waiting times are not as long. There seems to be a better capacity situation in the private system than there is in the public system at the moment.

As regards complex treatments, people do not give up their right to be treated as public patients if they have private health insurance. For complex treatment, people can still be treated in public hospitals as public patients. We would need to get waiting times down, however. People who currently have private health insurance are used to shorter waiting times. If one removes private treatment from public hospitals they may well face longer waiting times. There may be some push-back from people with health insurance in terms of any reforms to the system. That being said, we have to design the system for the population as a whole and not for any sub-segment.

The privatisation of the GP service is an interesting point. GPs are private contractors and they see a mixture of public and private patients Although every so often there are anecdotal stories to the contrary, by and large there is no discrimination between public and private patients in GP care. That is certainly something from which we can learn. Why is it that GP services are accessible by all patients, whether public or private, within a reasonable timeframe? Could we replicate that in the public hospital system, at least in the short term, while we move to try to disentangle the public-private overlap?

Affordability is an issue in tax relief. There is a temptation to characterise the public-private divide as haughty businessmen with bunions kicking little old ladies on social pensions with heart conditions out of beds. It is not quite as caricatured as that. About one third of those with private health insurance are in the C2 or DE social classes, which would be typically referred to as working class people. Therefore, membership of private health insurance schemes goes right across the social strata in this country. Obviously, however, those on lower incomes will be most affected by any increase in price as a result of removing tax relief for private health insurance. The compensation for that would be that if one is investing money in the public system and the public system becomes more accessible, not as many people will require private health insurance in the first place.

The affordability of increasing capacity will be key. That is why, in my opening statement, I mentioned that we need to be upfront about this. It will cost a lot of money. We are not talking about hundreds of millions but billions if, for example, we were to increase our bed capacity by 9,000. I do not think it will happen, certainly in the next ten years, but our current bed capacity is roughly 15,000 so we are talking about a 60% increase. Let us say that we increased bed capacity by 50% in the public sector. The Central Statistics Office, CSO, figures suggest that, in 2014, Government spending on hospitals was about €4.5 billion. Therefore, by increasing capacity by 50%, we are talking about roughly €2.25 billion, although there are a lot of adjustments to be made.

Chairman: Will Dr. Turner give us those figures again, please?

Dr. Brian Turner: The system account figures from the CSO suggest that Government spending on hospitals came to €4.5 billion in 2014. Therefore, if we were to increase public hospital capacity by 50%, for argument's sake, we are talking roughly about another €2.25 billion.

Chairman: Dr. Turner is only talking about bed capacity. What about all the other procedures that go on in hospitals?

Dr. Brian Turner: This is current spending, so that is not looking at the capital spending required to supply those beds.

Chairman: Yes, but not all the acute hospital sector public spending relates to inpatient activity.

Dr. Brian Turner: Yes, absolutely.

Chairman: There is all the other activity that we are talking about taking out.

Dr. Brian Turner: Exactly, and that is one of the adjustments we would have to make.

Chairman: So the estimate there does not really stand up.

Dr. Brian Turner: No. Those are purely back-of-the-envelope figures to give a sense of scale.

Chairman: Okay, but it is quite dangerous to be using ballpark figures that do not have evidence to support them. A few figures have been thrown out here this morning that could be contested, so we need to be careful about the use of figures.

Dr. Brian Turner: Yes, although one is talking in billions of euro in terms of increasing capacity in addition to the capital spending that would be required. Is it affordable? That is something the committee needs to examine in terms of how much one is willing to pay for our public health system. Using private capacity in the short to medium term is a pragmatic solution. Long term, however, we should be aiming for a separation of the two.

I am aware that the consultant contract and the recruitment of consultants is an issue, particularly in certain specialty areas. It would need to be looked at in the context of any contract renegotiations as to what would attract consultants. I have a debate every so often with a colleague of mine about how much consultants should be paid. His attitude is we should pay them whatever they want given what they do and what we do. He believes we should pay them a multiple of what we are on because they are saving lives.

Chairman: In terms of the evidence, surely we should be aiming for a European standard for what consultants are paid.

Dr. Brian Turner: Absolutely. I would look at relativity in earnings, which means relative to the average earnings figures of what consultants elsewhere are being paid. Obviously they will be paid reasonably good salaries.

Chairman: Okay, but we do not say we should pay them whatever they want.

Dr. Brian Turner: No, I am not suggesting that.

Chairman: I am sorry, but Dr. Turner quoted a friend of his saying it. Let us slow down a bit on that.

Dr. Brian Turner: Yes, I am sorry. Deputy Durkan said that medical economists are public enemy number one, but I would like to think we are not.

Deputy Bernard J. Durkan: It was just a reaction out there.

Dr. Brian Turner: Yes, but I certainly have not seen too many health economists in Ireland calling for reductions in bed numbers in recent years. In fact, most of them are calling for the opposite, that is, increases in bed numbers. The reduction in bed numbers in the 1980s and 1990s arose from the financial situation at the time. It was not necessarily something that was requested. It was more about trying to live within means. In terms of health services having an insatiable appetite for money, it is an unusual service in being very much demand led on the basis that if it is built, people will come. We have limited means to provide health care, yet we have not quite unlimited needs for health care but very significant needs. It is rare to find a system where everybody can be treated within a reasonably short space of time when needed. There is always some rationing of health care. That is why it is necessary to have a waiting list because that is one way to ration it. Another way is on the basis of affordability but that gets into a two-tier system. Waiting lists are a rationing mechanism. That is cold comfort to those on waiting lists. Every country that I know of has some degree of waiting for medical services. It is a case of what is an acceptable way. It is not normal for somebody to wait two years for an outpatient appointment. That is very high by international norms. We need to bring that down.

To answer how other systems deal with demand, one of the reports often referred to in debates about international health systems is the European Health Consumer Index. On that index we do quite well in some respects. We need to acknowledge that we are getting some things right. We are joint eighth out of 35 countries on prevention and joint tenth on outcomes, but we are falling down on accessibility where we ranked joint lowest.

Chairman: That is some position to be polling.

Dr. Brian Turner: That is in the 2015 survey. Interestingly, we are ranked joint first on pharmaceuticals.

Chairman: What does that mean, on usage?

Dr. Brian Turner: It means access to pharmaceuticals. We are overspending on pharmaceuticals relative to other countries but at least we are ranked number one on that.

Many people pointed to the high rank of the Netherlands as evidence that managed competition, the system introduced there in 2006, was working. Interestingly, it was ranked either first

or second in 2005, in other words, prior to the reforms, so it was getting something right. The Netherlands has had problems particularly in respect of affordability in recent years.

Someone mentioned that consultants can work only a certain number of hours per day. In conversations with some consultants, they point out that they have access to theatres for only a certain number of hours in the day. They could make more use of the theatre time if it were available to them.

The optimal consultant number per 1,000 head of population is hard to say. The figure of 2.7 doctors per 1,000 includes specialists and non-specialists. The Organisation for Economic Co-operation and Development, OECD, average is 3.3. It is hard to know exactly what is the optimal number. That is the OECD average but the health systems are designed in very different ways. Some would have a higher focus on primary care, some would rely more on secondary care. It is hard to put a figure on it but we are below the average in numbers of doctors per 1,000, and a lower than average proportion of those are specialists.

Deputy Buckley referred to the reallocation of funding.

Deputy Pat Buckley: I understood Mr. Turner to say that the funding could be reallocated better. Is he suggesting that it is not being spent properly or the resources are not being properly utilised despite the money that has gone into the health service?

Chairman: It is also a question of disentangling public and private money. Mr. Turner speaks of our need to spend lots of money. Can he put that in terms of the overall spend of €19 billion, which is pretty close to the top of the European spend?

Dr. Brian Turner: Based on the 2013 figures in the health system, we were ranked seventh or eighth in the OECD in terms of *per capita* spending. Just under €6 billion of that is private spending. Slightly over half of that again would be out of pocket payments and slightly under half would be private health insurance. A small element would be charitable spending. I mentioned in my opening statement the increased cost sharing in recent years in terms of the increased drug payment scheme threshold, the introduction of, and increase in, prescription charges, increased accident and emergency department charges and the increased statutory bed charge. If we were to try to reduce the burden of out of pocket payments and unwind the cost shifting that happened in 2008 and 2014, that would have implications for the approximately €3 billion spent on out of pocket payments out of that €19 billion. How far and how quickly to go would be a matter for discussion. Out of pocket payments, which is one of the most regressive forms of health funding, amounts to approximately €3 billion.

A new bed capacity review would be needed to get an exact figure. I am not sure we would need a bed capacity review to tell us we are under-resourced for beds. We would need a review to put a figure on it. In the meantime, there is probably broad agreement that we need more hospital beds.

Chairman: Deputy Durkan used a quote to the effect that the private sector is feasting on the public sector. Mr. Turner said that €3 billion of the €19 billion spend comes from private health insurance. How is it that 46% of the population is covered by private health insurance? Does that not imply a major subsidy from public to private?

Dr. Brian Turner: There are a few things going on in that figure. The subsidy element is one. By and large, private health insurance gives people benefits for hospital treatment. In recent years there has been more of a focus on giving money back on day to day benefits, such

as GP visits, physiotherapy, optical and dental services. There would not be the same kind of spending from private health insurance on items such as prescription drugs, long-term care and social services, or the social end of health care visits. They are focused on hospital services more so than other areas of the health system. Even within that, there is a subsidy as well. Approximately 13% of health care funding in 2014 came from private health insurance despite the fact that 46% of people were covered. There is a mismatch there in the allocation of funds.

Chairman: The implication of what Mr. Turner is saying is borne out in his presentation, that the private sector is so embedded in the public sector that there is significant transfer of funds from public to private.

Dr. Brian Turner: That has been addressed to a certain extent in recent years with the capping of tax relief at source on private health insurance premiums and the removal of the bed designation from 1 January 2014-----

Chairman: There are other issues in respect of consultant contracts.

Dr. Brian Turner: -----we are moving in the right direction but there is a way to go.

Chairman: Within hospitals and how they operate there is significant transfer of funding as well, with consultant contracts and use of public facilities by private patients. Would Mr. Turner accept that?

Dr. Brian Turner: I would.

Deputy John Brassil: I thank Mr. Turner. Approximately 50% of the population have private health care. When one adds the numbers of beds in private hospitals and private beds in public hospitals, about 50% of the beds are available to patients with private health care insurance. That percentage of the population are well treated because they have access to a service. It is very obvious that the other 50%, those who do not have private health care insurance, do not have the same access and are, therefore, not receiving the care they need. It is agreed across the board that once a person gets into the hospital system, he or she is well looked after; it is getting access to a hospital bed that is the problem. In his summary Dr. Turner states we need to consider the possibility of public hospitals treating public patients only. I want to focus on that very strong statement. How could we bring it about? Let us strip back the service. We are looking at better primary care and step-down facilities, but let us deal with the hospital issue. It is very obvious that a person who is economically more attractive to a hospital is given priority. That is happening. We have discussed the issue at length. Do we have to re-examine consultants' contracts, the contracts of nursing staff and those of staff at all levels? Is it necessary to have a complete revamp to make a service available? There might be staff in the system who might have a contract that is to run for another 20 years. Unless we tackle and deal with the issue, we will go around in circles. I would like to have more meat put on the bones in expanding on the particular comment made.

Deputy Michael Harty: I thank Dr. Turner for coming before the committee. I have two questions. When the CEO of the HSE, Mr. Tony O'Brien, appeared before the committee a number of weeks ago, he referred to the need for transitional investment funding to stimulate a change in the system to make it more efficient, change the emphasis from being on secondary care to primary care and begin the transfer of resources from secondary care to primary care services. What is Dr. Turner's view in that regard?

My second question is on the funding of a new single tier service. Dr. Turner suggests use

of the taxation system is better than use of a social insurance system. In that regard, will he comment on the necessity to have co-payments for certain services? There would be a suite of services that would be free at the point of delivery but for other services there might have to be a co-payment or there would be others that would not be part of the single tier system.

Deputy Joan Collins: I wish to comment on the statement that the private sector feasts on the public sector. This applies not only to bed capacity but also to staff. Last week we heard that the majority of staff in the private health sector came from the training schools in public hospitals. That is a phenomenon that needs to be dealt with, given the staff shortages in public hospitals and that the IMNO is stating it is unsafe for nursing staff to work owing to insufficient staff. It has highlighted the need to recruit and retain staff. The significant question is how can public hospitals recruit and retain staff? This is linked with the point Dr. Turner made about the need for 2,800 additional doctors, as well as extra nurses, GPs and so on. If we are to have a public health service to which people will want to buy in, we need to increase capacity. We need consultants, nurses and other staff whom we need to keep in the public sector. We could decide to recruit and train 150 student nurses annually in the next five years, but how would we retain them in the public health sector? That is the question the committee must consider. One suggestion is that the public sector pay for the training of doctors and nurses if they remain in the public sector for 20 to 25 years. Does Dr. Turner have a view on how the public sector could benefit from the expert training medical students receive in Irish colleges and retain them in the public sector?

Dr. Brian Turner: Deputy John Brassil is correct when he states roughly half the population have very good access to care. When we read analyses of the health system we tend to look at the overall funding for the public and private sectors and focus on the worst outcomes which tend to be in the public system. There is a dichotomy in access to hospital care, in particular.

On how we would achieve a single tier public hospital system which would focus on public patients only, we need to renegotiate the consultant's contract. I am not sure of the numbers, but to the best of my knowledge there are still some consultants on the old category one and category two contracts. The new category A consultants have been contracted to work in public hospitals only. The category B and category C consultants have different terms and we need to re-examine these contracts. One possible way of doing so is to say that if a consultant is able to treat private patients, he or she can only do so in a private hospital. I think the old category two consultants had an entitlement to engage in private practice off site, whereas the new category one consultants do not. If one wants to treat private patients, one should treat them off site. Another option which was discussed in the context of hospital trusts five or six years ago would involve a consultant being contracted to work for a hospital or a hospital group and only being allowed to work within that group. As I am not an expert on contract law, I do not know how one would do that.

On incentivising the treatment of public patients, having the money follow the patient might help in that regard. The difficulty is how would one cap the numbers to ensure spending on hospital patients would not spiral out of control because it is a demand-led service. Again, it would depend on the relativity in reimbursement for treating a public and a private patient. Currently, having an additional public patient does not mean any additional income, whereas having an additional private patient does. Under a system under which the money would follow both patients would bring additional income. Therefore, it would become a matter of relativity, but the incentives would be greatly reduced in that regard.

Deputy Michael Harty raised the issue of transitional investment funding. It will certainly

be needed because before we start to move patients out of hospitals, we will need to ensure the necessary infrastructure at primary care level is in place in order that they will not fall through the cracks.

On the funding of health service reform, it must be borne in mind that costs will accrue in the short term, whereas savings will accrue in the long term. This might prove difficult politically. That is the reason having a ten year plan is worthwhile. On the issue of taxation versus social health insurance, while I am not against the latter, we already have a tax based system and I do not think the nature of the funding is the issue. I do not think a move to social health insurance will necessarily improve matters for us. It will, however, take up a lot of resources in terms of time and effort. I do not see that as being a necessary step towards improving the situation.

There is some merit in the co-payments option. The report from the group chaired by Professor Frances Ruane which was published in 2010 looked at that issue in the context of payments for GP services. The report suggested that people below a certain income threshold would not pay anything for GP services, while people in the next income band would pay no more than €5, those in the next band would pay no more than €10, those in the next band would pay no more than €20 and so on. Such a model, with a certain amount of co-payment linked to income, might work. The roll-out of free-at-the-point-of-use GP care does not necessarily have to mean that all GP visits are covered. We could decide that everybody gets five free GP visits per year and after that we go with the banded co-payment system as suggested by the Ruane group. There are options there that could be explored further.

In terms of services, anything that is not medically necessary should not be covered under a universal, tax-funded health care system. For example, if someone wants cosmetic surgery, the taxpayer would not be happy paying for that. If a service is medically necessary, then it should be either free at the point of use or available with a subsidy or some kind of co-payment, depending on the nature of the service. Not everything has to be covered.

Deputy Joan Collins asked about recruiting and retaining staff in the public sector. That is certainly an issue and I do not have a short answer to it. I am not sure exactly how to do it. I certainly would not be opposed to having a stipulation that people who received their medical education in Ireland, subsidised by the State, should repay the State by working for a certain length of time in the public system after graduation. That would be an acceptable way of getting junior staff into the system. The issue then is how to recruit and retain senior staff, which is more complicated. If the necessary investment is made in the health system and if it becomes a better system in which people to want work, that will help. Part of the problem at the moment is that some elements of the system are quite chaotic and frustrating for medical personnel but if we invest in the system and improve it, some of that will naturally dissipate and we might be able to recruit and retain more senior staff. Certainly at a more junior level, the idea of a payback for the State subsidisation of medical education is a worthwhile option to pursue.

Chairman: On the issue of staff figures, some estimates were given earlier which are not necessarily supported. It is important to point out that we are not proposing to ban private health care. We would not have the power to do that. Indeed, all countries have some element of private health care. We are not talking about eliminating all that or eliminating the jobs in that sector.

The other point we are making is that with a properly functioning public health system, we would need to greatly expand capacity, both in primary care and hospital care. We would envis-

age significant numbers of people being recruited to the public sector in order to provide critical primary, community and social care supports. It is six of one and half a dozen of another and it is important not to engage in any kind of scaremongering in that regard.

Deputy Kate O'Connell: I apologise for being late and hope I do not repeat questions that have already been asked of the witness. Deputy Harty made reference to a suite of services but I would prefer to call it a menu. Who does Dr. Turner believe is best placed to draw up the basic menu or suite of services to which people will be entitled? How will that be worked through?

Deputy Barry spoke about moving things from one system to another. Does Deputy Barry's analogy assume that demand is static and that nothing new emerges as a treatment? Let us say we are moving services from the private into the public health system. Our population is increasing and ageing and at the same time, the costs of modern medicine, with drugs being a prime example, are escalating. In that scenario, we will be fighting a losing battle. Demand for services, whether essential or non-essential, will be constantly increasing. I ask Dr. Turner to outline his views on that.

Dr. Turner's opening statement refers to out-of-pocket payments and suggests that the roll-out of universal access to GP care should involve increasing the income threshold on the GP visit card. The logic behind giving universal access to children under six was to get them into the system early. I know that many questioned why people with sufficient means should be able to bring their children to the doctor for free. Speaking as a community pharmacist, I know that during the recession I was often faced with the difficult decision of whether to refer someone with three children to a doctor because it could cost €150. Even people with a good income might not have €150 to spare. I believe that free GP care for children under six is a good thing. That said, I have three children under six and I am probably more likely to bring them to the doctor now.

Does Mr. Turner believe it would be better to improve access for people with co-morbidities, like diabetes, obesity, heart conditions and maybe cancer? Should we not try to deal with people with complex medical needs before giving universal access to, for example, 12 year olds who have no major medical needs? How can one justify providing access to one group over another, even on an economic basis?

In terms of barriers to GP access, Dr. Turner suggested that we could consider giving everyone five free visits per year and then charging for any additional visits. I ask him to elaborate on where that idea comes from and to outline whether there is research to back up the suggestion that five visits per year would be enough. Would someone who is asthmatic, for example, also be entitled to half an hour with a specialist nurse per year?

On the question of disentangling the public and private systems, how would we go about doing that? Does Dr. Turner believe that doing it on a specialty by specialty basis would be the way forward? Before Christmas we discussed maternity services and the fact they are universally accessible, although many people opt to pay for private maternity care. Would that be a good place to start? Those who opt for private care pay approximately €3,000 on top of their private health insurance in order to have a consultant leading their care. They do so because they believe it is the safer option. If we roll out the national maternity strategy and implement it in full, resulting in more confidence in the public system, then that might be a good place to start in terms of disentangling one from the other.

Dr. Turner referred to the need for more money. This seems to be a constant issue. At al-

most every meeting, the Chairman refers to the fact our health spending, *per capita*, is one of the highest in the OECD. I am conscious of a demand-led system and this unsustainable draw on revenue, especially when in another section Dr. Brian Turner said the system is not maximised and doctors are not used to their optimum because there are no theatre or scanning staff, for example. I am concerned an economist would say we should give more money without creating efficiencies or making the system better.

What I took from Dr. Brian Turner's point about consultant pay is that it is not a pure matter but must be related to the average industrial wage or relative to living expenses. Does he have data on why Ireland is unique and unusual in that we are required to spend almost the highest in the OECD on consultant pay? Obviously, we are spending the highest in the OECD *per capita* but that is because of houses, school fees, wages, etc, impacting on that.

Dr. Brian Turner referred to the reduction of bed numbers in the 1990s due to the financial situation then. I assume that was never rolled back on or compensated for when times became good. Was that reduction ever addressed when Exchequer funding was available? Will he elaborate on his statement that waiting lists are one way to ration services? Is that hoping that people will get worn out waiting or might die?

Chairman: Dr. Brian Turner has time constraints and the Trinity team is waiting outside to attend. However, I will allow two quick supplementary questions from Deputies Louise O'Reilly and Barry.

Deputy Louise O'Reilly: Dr. Brian Turner referred to the possibility of medical staff giving back after their education and training. It is an issue with which I have a problem. This is never suggested for architects or anyone else who has the capacity to avail of a good education system. Can we find a way to incentivise our health professionals? It is not that long ago when nurses left college, went abroad for six months or a year and then came back to work in the public health service. There was no need to coerce them to do so. If we insisted health professionals had to give back, would Dr. Brian Turner not agree we would have to do it for every cohort of professionals? I do not know what arts graduates like myself would give back.

Deputy Mick Barry: Chair, I just want to register one point briefly. We heard evidence at the committee late last year from Professor Allyson Pollock of Queen Mary University of London in which she stated the committee might consider the Canadian model. The two characteristics of this model, as she presented it to the committee, are that it is a tax-based, single-tier health care system, free at the point of use, somewhat like the National Health Service in the UK, but perhaps taking a step further down the road. This is linked to a ban in Canada on private health insurance. Professor Allyson Pollock suggested this could be considered as an option by the committee. I object to that approach being described as scaremongering.

Chairman: Sorry, I did not say that.

Deputy Mick Barry: I thought you indicated that as scaremongering.

Chairman: No. I was talking about the suggestion of large numbers of job losses.

Deputy Mick Barry: Absolutely, we would all be opposed to job losses. Instead, we hope jobs will be maintained in the public health care sector. I hope this option is still on the table and up for discussion.

Chairman: I will allow Deputy Durkan back in. He is allowed one sentence only.

Deputy Bernard J. Durkan: How do hospital services, and medicine generally, in other European countries maintain their quotas of medical professionals? They do not seem have a problem recruiting or holding on to them.

Chairman: Thank you, Deputy.

Dr. Brian Turner: On Deputy Kate O'Connell's question on who should determine medical services, it has to be clinician-led. Based on the thematic review of responses received on the White Paper on the universal health insurance proposal, one area of concern for many was with the basket of services. This would need to be handled carefully. Who decides what services are covered in public hospitals now? It basically seems to be medically necessary services. I am not sure there is a menu anywhere of what that covers.

Demand is increasing on an ongoing basis. If one looks over time, the proportion of GDP, gross domestic product, spent on health care across the world is on a long-term upward trend. There have been debates in several countries about sustainability. A good report written by John Appleby for the King's Fund in 2013 suggested public spending on health in Europe, as a proportion of GDP, could increase from 6.7% to 13% by 2060. He discussed sustainability issues around that. There is no assumption that new treatments do not become available. Medical technology is improving all the time. If anything, there is an implicit assumption that treatments will advance on that.

On the changing eligibility for GP-visit cards from age-based to income-based, I was looking at it from the point of view of who has the most trouble accessing services and for whom is there a significant financial barrier to accessing services. There are two groups, namely those who visit their GP more often and those on low incomes. With the under-sixes and the over-70s, we have largely covered the people who visit more often. In expanding it to the six years to 11 years age category, I stated in a submission to the public consultation on this that at the press conference on budget 2015, the then Minister, Deputy Varadkar, suggested expanding free-at-the-point-of-use GP care to that age group would not cost a huge amount because the capitation rates are lower as that age category would not visit the GP as often.

If that category does not, then maybe we should focus instead on those for whom there is a significant financial barrier to accessing GP services. The people who delay going to their GP may end up needing hospitalisation by the time they go about getting treatment. There are always trade-offs and no right or wrong. My suggestion, however, would be that we should focus on income rather than age. Those with complex needs is another issue to be considered.

On the question of a certain number of visits per year, I threw five out there as an example. The Central Statistics Office quarterly national household survey module on health in 2010 broke down the number of GP visits per year by various different cohorts. If memory serves me correctly, the average number of GP consultations among adults who reported those consultations was 4.3. If we include the number of people who did not see a GP, then the average number of consultations was 3.2. There is evidence to suggest that the typical number of visits per year is somewhere between three and four. Obviously, that is complicated by the fact that some patients have medical cards and would tend to go more frequently. Others may be younger and, therefore, would go less frequently. If one were to go down that road, more analysis would be needed to come up with a figure. That is one option to deal with it.

I was asked about distinguishing between public and private health care. The provision of maternity services is an interesting example. In Cork, Cork University Maternity Hospital is

the only show in town in terms of maternity services. Public and private patients are mixed together there. Maternity services are unusual in that we cannot exactly have a waiting list for certain maternity services. Maternity services are also unusual in that they are not fully covered by health insurance. There is a significant co-payment, even for those who have private health insurance. Certainly, it is an example of where we could start to examine the system.

Reference was made to the high health spend *per capita* relative to the OECD average. Yet, people say more resources are needed. Again, to a certain extent this stems from the under-funding for over a decade in the 1980s and 1990s and the fact that the resulting deficit was never fully unwound. Our bed numbers are still below what they were in 1980. The number is approximately 15,000 at the moment, compared with 18,000 in 1980. We are below the historical figures in terms of bed numbers.

A question was asked about moneys versus efficiencies. I do not think it is a question of either one or the other. We need to spend more but we also need to ensure that we spend wisely and that efficiencies are harnessed.

Reference was made to waiting lists as one way of rationing care. I am not for a moment suggesting that people should be made to wait until they give up. From an economic point of view, no health system in the world has sufficient resources to give everyone the care they need when they need it. Resources have to be rationed in some way. The use of waiting lists is one way of rationing services. Eligibility to services on the basis of ability to pay is another way to ration services, but it probably has more adverse consequences for those who cannot get into the system.

Deputy O'Reilly referred to the possibility of medical staff being asked to stay on while we do not ask the same of those working in other areas. To a large extent we do not have the same shortages in others areas as in health. However, I understand Deputy O'Reilly's suggestion that we are perhaps singling out one cohort.

The question of incentivising health professionals to work in Ireland or to return to Ireland was raised. Again, if we invest in the system and improve the public system, there will be a natural element of people seeking to work in the system or, to put it another way, not wanting to not work in the system.

Deputy Barry referred to the Canadian system. I would not profess to be an expert on the Canadian model. I was under the impression that rather than private health insurance being banned, there is a ban on private health insurance covering anything that is covered by the statutory system. In other words, private health insurance can cover care not covered by the statutory system and it operates purely as a complementary health insurance system. I am open to correction on that point. Certainly, the Canadian model has been proposed as a good model, although in terms of health spending as a proportion of GDP, Canada is at the higher end of the scale. I gather it is one of the higher spending countries, notwithstanding the fact that we are, temporarily at least, one of the highest spending countries.

Another point to note relates to the peculiarity of the figures in looking at health spending as a percentage of GDP. Given the 26% increase in GDP in 2015, our health spending as a percentage of GDP in 2015 will, I imagine, suddenly come down below the OECD average again. We will come down the rankings simply because our GDP has gone up and the denominator has increased. Health spending *per capita* may be a more useful measure in that sense.

Deputy Durkan asked about the hospital services generally retaining and recruiting professionals in other countries. The honest answer is that I am unsure how they do it or what the mechanics are. Certainly, we are facing a shortage of professionals. Some other countries are below the OECD average in this regard. However, I have not undertaken any investigations into why that is the case – I would rather not hazard a guess.

Chairman: Thank you very much, Dr. Turner. I appreciate you coming in, the time you gave us this morning and your responses to the questions from members. We will suspend and resume in private session when the Trinity team will be in to update us on the drafting of the plan.

The select committee went into private session at 10.55 a.m. and adjourned at 11.55 a.m. until 9 a.m. on Wednesday, 1 February 2017.