Budget 2013 and 'Future Health'

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Introduction

Having been in hospital in Ireland in early 1979 for minor surgery, Elizabeth Shannon, the wife of the then US ambassador to Ireland, wrote in her diary as follows[1]:

"Irish hospitals are wonderfully kind, warm places, very unlike my scanty experience with American hospitals. The nurses, many of them nuns, are patient, humane and understanding. Doctors have time to talk to patients in a reassuring and unhurried manner. I think I shall come back to Ireland if I ever need to be hospitalised. The medical care is excellent, the nursing care superb, and the rules....well, relaxed enough to make recovery fulfilled with laughter, surely a good medicine for everyone."

I wonder what her reaction would be if Elizabeth Shannon came back today for a similar procedure, 33 years after her first idyllic experience? Few aspects of Irish life today are as much criticised as the health service. Can we ever again find the nirvana she evoked? For many readers of a certain age, "bring back the nuns" would be a preferred solution, but there are no nuns to bring back.

Future Health - A Strategic Framework for Reform of the Health Service 2012 – 2015 was issued by the Irish Department of Health and Children on November 15, 2012.[2] It is hugely significant in that, if acted upon, it will affect our well-being and economic and social performance like no other initiative. If we get it wrong, it will cause huge damage. If we get it right, it could be transformative in a positive sense.

Outcomes and Cost Evidence

The key reference for this section is *Health at a Glance Europe 2012*, OECD Paris, 2012[3] the result of a collaboration between the European Commission and the OECD.

From a policy point of view, what is of particular interest are those areas where we are excelling in an EU context, and those where we are doing badly, defined as being in the top 5 (excelling) or bottom 5 (doing badly). Most rankings are out of a total of 27, with 1 being best, and 27 being worst in the EU. The data in Annex Table 1 summarise the situation, from which the observations below are drawn.

The Irish system has excelled at some things – notably the reduction in mortality – and performed poorly at others, notably incidence of cancer. A logical next step for a strategy would be to tease out what factors are most likely to explain excellence and the opposite – i.e. what mix of medical intervention, genetic endowment, social and cultural norms and wider policies explain performance. This would set the stage for an analysis of the combination of policies within and outside the health

[1] Shannon, Elizabeth,1983. *Up in the Park – the Diary of the Wife of the American Ambassador to Ireland 1977-1981*, Gill and Macmillan, p. 177

[2] http://www.dohc.ie/publications/pdf/Future_Health.pdf?direct=1

[3] Available at: http://www.oecd.org/els/healthpoliciesanddata/HealthAtAGlanceEurope2012.pdf

sector per se that could improve performance in manners that are cost effective and fair. The Report of the Expert Group on Resource Allocation[4] chaired by Frances Ruane identified pathways whereby progress could be made, with a particular focus on aligning the incentives faced by the key players in the system with what is desired.

The costs of the Irish system are astonishing. An analysis by Paul Redmond[5] adjusts for our very favourable demographic profile This adjustment is especially relevant in the case of Ireland, because we have a relatively small share of the population over 65 (11.1%) compared with the rest of Europe – e.g., Germany (20.5%), Italy (20.4%), France (16.7%). Gross National Product (GNP) is used for Ireland instead of Gross Domestic Product (GDP)[6].

He concludes that we have the most expensive health system in the European Union, and the third most expensive in the world. As such, it is a considerable drag on economic performance, since more resources are tied up unproductively. This is the bad news. The good news is that this allows considerable scope for reform, and for releasing resources that could be more productively used. The OECD ranks the Irish health system 28th out of 28 in terms of productivity.[7]

"It has measured the potential impact of a range of structural reforms that can impact directly upon productivity and can directly improve national fiscal positions while maintaining current outcomes. This analysis suggests that Ireland could save up to 0.25% of GDP through educational reform (Education is ranked 3rd out of 24), and more significantly, 4.8% of GDP through reform of the health care system".

In terms of human medical resources, we rank number 2 in the EU for number of physicians. The OECD data[8] tells us however that we have the highest proportion of generalists (66%) in Europe. This implies that the specialist share (now totalling 34% - the lowest share in Europe) should be increased. Our top ranking in terms of number of nurses per capita deserves analysis, and specifically, to net out those in management and administration. It may also be the case that they are doing work which in other jurisdictions is done by other professions, such as social workers.

[4] Department of Health and Children, 2010. *Report of the Expert Group on Resource Allocation and Financing in the Health Sector*, Dublin. Available at: **http://www.dohc.ie/publications/resource_allocation/resource_allocation_report_hiRes.pdf?direct=1**

The group's work was supported by a very useful research report: Brick, A., Nolan, A., O'Reilly, J. & Smith, S. (2010) *Resource Allocation, Financing and Sustainability in Health Care: Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector*. Dublin, Department of Health and Children and Economic and Social Research Institute. Available at: http://www.esri.ie/publications/latest_publications/view/index.xml?id=3059

[5] Redmond, Paul 2012. Expenditure and outputs in the Irish Health System- a cross country comparison. Publicpolicy.ie, November 2012 available at : http://www.publicpolicy.ie/wp-content/uploads/Expenditure-Outputs-Irish-Health-System.pdf

[6] The former measures income accruing to residents of the country, while the latter values total output of goods and services. For most countries, they are roughly the same, but in Ireland, because of the substantial repatriation of profits by multinational companies located in Ireland, GDP is much larger than GNP and does not well reflect the actual well being experienced by residents. See de Buitleir, Donal. 2012. *International Comparisons of Taxation and Public Spending and GNP/GDP* for details, available at: http://www.publicpolicy.ie/wp-content/uploads/International-Comparisons-of-Taxation-and-Public-Spending-and-GNP-GDP.pdf

[7] Taken from: National Competitiveness Council, 2012. *Ireland's Competitiveness Scorecard 2012*, Forfas, Dublin, p. 51

[8] OECD (2012), p. 69

Key elements of 'Future Health'

The case for change is made on the basis that the aging population is growing – expected to increase by 54% by 2025, and the numbers aged over 85 will double. Incidence of chronic disease – which accounts for around 70% of health resources - will increase by about 40% by 2020. This implicit increase in demand will have to be met while resources shrink. Reform is essential.

Some key elements in the strategy include:

- Universal Health Insurance to be introduced from 2016
- Free GP care for all to be introduced in 2015
- A new patient safety agency to be set up in 2013 next year and a health and wellbeing agency in 2015.
- A reorganisation of services by hospital groups, on a trial basis at first.
- Control of health spending to return from the HSE to the Department of Health in 2014
- The introduction of new financial management systems aimed at controlling costs.

Conclusions and Implications

Clearly, with limited resources and rising demand because of the aging population and emerging (expensive) treatments and technologies, reform of our systems of healthcare is essential if quality is to be maintained, and if the drag on the economy is to be reversed.

1. 'Future Health' Does Not Represent a Credible Reform Effort

Credibility is about convincing the public and the key actors that what is proposed makes sense, and that it can and will happen. Not everyone shares my enthusiasm for independent evidence, but neither am I alone; our experience at publicpolicy.ie is that there is a growing constituency for verifiable facts. 'Future Health' does not meet minimum standards in this regard – hardly any numbers, no references, no background notes explaining the strengths and limitations of the proposals, and a strange paucity of visual prompts –pictures, graphs, flow charts, tables etc. So its credibility is already impaired, in the context of a sector that already suffers a considerable credibility gap. If we don't tackle the choices - especially the 'how', on a careful scrutiny of the evidence, in 2016 we are likely to be chanting Hardy's catchphrase to Ollie: "Well, here's another nice mess you've gotten us into!"

2. There should be a rule at cabinet that no proposals from any government department will be admitted for consideration unless it meets minimum standards in this regard.

The imperative of good policy analysis is evident at European level, where for any significant policy proposal, the European Commission must undertake an impact assessment, which is based on an integrated approach which analyses both benefits and costs, and addresses all significant economic, social and environmental impacts of possible new initiatives.[9] It would demonstrate a certain maturity and respect for the citizenry and tax payers if we were to adopt and apply this precedent. It will necessitate having in place a policy analysis team that has up to date knowledge of the data and

[9] http://ec.europa.eu/governance/impact/index_en.htm

the literature, that understands policy instruments, the role of incentives and behavioural science, and the importance of interaction and engagement, both intellectual and practical.[10]

3. Focus Attention on the 'how'

The arguments contained within 'Future Health' for more integration, achievement of scale economies by grouping, money following the patient, the aligning of incentives to achieve the outcomes desired, the separation of purchasers and providers, etc. all make sense. But how they are going to be achieved is not explicitly addressed, beyond organisational changes, led by the Programme Management Office which will have 'central, overarching coordination function for health reform.'

4. In addition to the usual suspects, engage with those who have an interest in cost containment

A worrying element of 'Future Health' is that 'active support will be sought of patients and clients, advocacy groups, health and social care professionals, health system managers, other workers, professional bodies and staff associations, the Oireachtas the wider political system, government departments, relevant statutory bodies, colleges and institutes, EU and other international bodies.' Most of these will be pushing vigorously to increase expenditure and expand services. There also needs to be some grit in the system that vigorously questions such propositions, that demands credible evidence, and that in effect represents the wider tax payers who will have to pay for same.

5. Involve the OECD

'Future Health' does not flag the OECD insights, including the reform measures they envisage. This is an important gap, in terms of both identifying measures that should be included in the strategy, but also in terms of benchmarking the reform process. The OECD should be invited to review and evaluate the Irish proposals, and to monitor and report on progress as it evolves. We need serious and periodic international peer review if the reform process is to have credibility and to stay on track.

The OECD data show that the Irish system does excel in some areas. There is no attempt in 'Future Strategy' to learn from these, or from the areas where performance is very poor. It is important to recognise world class achievements where they are to be found, to understand what brought them about, and what lessons can be learned for the rest of the system.

6. Adopt Graduated Access to Primary Care

A core proposal of the strategy is to provide free access for all to GPs. This is justified on the basis that there is a "body of evidence that user fees are a barrier to accessing care at the primary care level and thereby cause late detection of illness, poorer health outcomes and greater pressures on the acute hospital and long term care systems." But there is also a body of evidence that when prices fall – and especially when they fall to zero – demand rises; with this policy change, we can expect far more pressure on the GP services, with waiting lists and queuing as a likely outcome.

[10] There is a welcome commitment in 'Future Health' to both improve the policy analysis analytic capacity, and to promote research and development.

I prefer the illustrative proposal to create a graduated set of Medical Card entitlements that came from the Ruane Resource Allocation group[11], namely:

- **The Standard Card**: capped GP and prescription drug fees for all who register with a GP
- **Standard Plus Card**: reduced capped fees and cheaper prescription drug fees for those with chronic illness and incomes between 40-50% of the average
- **Enhanced Primary Card**: further reductions in fees and the cost of prescription drugs for those with chronic illness and incomes between 30-40% of the average
- **Comprehensive Card:** No fees or prescription costs for those with incomes under 30% of the average. This is identical to the current medical card.

This hews to the spirit of access to all and is consistent with the commitment in the Programme for Government, but does embody elements of cost containment, fairness and incentives not to overload the system. The graduated system also reduces the dangers of a poverty trap, whereby if you 'lose' the card, you lose all other entitlements.

7. Hire More Specialists

Considerable damage to the provision of health services in Ireland seems to be attributable to the Common Contract agreed in 1997 for specialists; because of its ambiguities and generosity[12], it has been a vehicle whereby some specialists have captured rents on a grand scale, comparable to those generated when the mobile phone licence was allocated (rather than auctioned) in 1995. This in turn has engendered a reluctance to hire sufficient specialists to meet needs, with consequent stresses and inadequacies. The supply needs to be expanded to international norms, at pay and conditions that also reflect international norms.

8. Incorporate Housing with care as an option for older people

As we get older, and more dependent, international experience shows that, for most, the hierarchy of preferences is first to stay at home, then move to what is variously characterised as assisted living, housing with care, or supported care, and then finally to nursing home where more or less complete dependence is characteristic. The key is to maintain independence and as much autonomy as is feasible for as long as possible. Although the second stage – housing with care – is characteristic of most economically developed societies, it is largely absent in Ireland.[13] Including this strand should be an explicit element in the review of the Fair Deal scheme [the fact that this is titled 'The Nursing

[11] See: http://www.esri.ie/news_events/latest_press_releases/publication_of_report_of_/index.xml.

[12] Details available at: http://www.audgen.gov.ie/documents/vfmreports/55_MedicalConsultantsContract.pdf. A revised contract was agreed in 2008.

[13] See: Dutton, Rachel. 2009. *'Extra-Care' Housing and People with Dementia, A Scoping Review of the Literature 1998-2008,* Housing and Dementia Research Consortium with funding from Joseph Rountree Foundation for emerging trends internationally for one segment of the ageing population.

Home Support Scheme' tells its own story]. Dying with dignity, tranquillity and no pain should be available to all, and the Hospice movement in Ireland has an excellent record in this regard. The commitment in regard to palliative care is welcome.

9. Clarify Nurse Numbers

It is important to verify (or not) if we are indeed the most nurse-intensive health system in Europe. The outcome will have considerable implications for resource allocation.

And let's bring back Elizabeth Shannon in 2014 – 35 years after her happy experience in an Irish hospital – and get her judgement as to whether we continue to deserve her endorsement...

Annex Table 1 Some Comparative Health-Related Outcomes and Activities in an EU Context, Ireland, 2010

Outcomes and Activities	Indicator	Ranking	Comment
Excelling		Ranks are from the best (1) down	
Decline in mortality rates from all causes, 1995-2010	Per cent change from 1995-2010 (37%)	1	Ireland has also seen a decline of close to 40%, driven largely by reductions in cardiovascular and respiratory diseases mortality, which in turn may be linked to rising living standards and increased expenditure on public and private health services in recent decades."(OECD, 2012, p. 20)
Stroke mortality rates 2010	Age standardised rates per 100,000 (37)	3	Strokes ..are the lowest in Cyprus, France, Ireland and the Netherlands. Rates are also low in Switzerland, Iceland and Norway.(OECD, 2012, p. 24)
Lung cancer mortality rates, males and females, 2010	Age standardised rates per 100,000 (48)	4	
Transport Accident Mortality Rates, 2010	Age standardised rates per 100,000 (4.2)	4	Reductions in Ireland, Portugal and Slovenia and a number of other countries are more than 60% since 1995, although vehicle kilometres travelled have increased substantially in the same period (OECD, 2012, p. 26)
Good or very good health (self-reported), 2010	% of population 16 and over (83%)	1	In Ireland and Sweden, as well as Switzerland, more than eight out of ten people report good or very good health. (OECD, 2012, p. 34). Demographic structure is a big factor here.
Adults reporting a limitation in usual activities, 2010	% of population 16 and over (5.2%)	4	Demographic structure is a big factor here.
Smoking among 15 year olds (at least once a week), 2009-10	% of population 15 years old Boys (12%) Girls (14%)	4	
Daily vegetable eating among 15 year olds 2009-10	% of population 15 years old Boys (39%) Girls (42%)	4	
Daily moderate to vigorous physical activity 11 and15 year olds, 2009-10	% of population 11 and 15 years old (43%)	1	
Daily fruit eating among adults, 2008	% of population Males (70%) Females (78%)	4	
Daily vegetable eating among adults, 2008	% of population Males (95%) Females (96%)	1	
Performing Poorly			
Breast cancer mortality rates, females, 2010	Age standardised rates per 100,000 (26.2)	24	
Change in suicide rates, 1995-2010	Percentage change, 1995 to 2010 (-3%)	22	Improvement is small, but absolute level is lower than EU average
Breast Cancer incidence rates, 2008	Age Standardised rates per 100,000 females (94)	23	
All cancer incidence rates, males and females, 2008	Age standardised rates per 100,000 (358)	26	In 2008, the incidence rate for all cancers combined was highest in Northern and Western Europe – Belgium, Denmark, France, Iceland, Ireland and Norway – at over 290 per 100 000 population, but was lower in some Mediterranean countries such as Cyprus, Greece, Malta and Turkey, at less than 220.

			(OECD, 2012, p. 40)
Prostate cancer incidence rates, males, 2008	Age standardised rates per 100,000 (126)	27	At least part of the five-fold difference between countries with the highest and lowest incidence rates is due to under-registration of prostate cancer in some countries, as well as the use of sensitive diagnostic tests for early detection in others The rise in the reported incidence of prostate cancer in many countries since the 1990s is due largely to the greater use of prostate specific antigen (PSA) tests. (OECD, 2012, p. 40)
Reported overweight among 15 year olds, 2009-10)	% of 15 year olds (12%)	21	
Adult population smoking daily	% of population 15 and over (29%)	25	
Change in per capita alcohol consumption, 1980 to 2010	% change over the period (24%)	26	
Prevalence of obesity among adults, 2010	% of adult population Males (22%) Females (24%)	25	The growth in overweight and obesity rates among adults is a major public health concern. Obesity is a known risk factor for numerous health problems, including hypertension, high cholesterol, diabetes, cardiovascular diseases, respiratory problems (asthma), musculoskeletal diseases (arthritis) and some forms of cancer. Mortality also increases sharply once the overweight threshold is crossed (Sassi, 2010). Because obesity is associated with higher risks of chronic illnesses, it is linked to significant additional health care costs. OECD, 2012, p. 62)