

Comments for Oireachtas Committee on the Future of Healthcare

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The decision to have a universal public health care system is always political. Many countries have decided that universal health care (access to services on the basis of need and free at the point of delivery) is the hallmark of a civilized society and that it is both necessary and affordable for governments to legislate for its citizens to that end. The question of how much any country should spend on public health care is inextricably linked to the chosen model of funding and provision, the degree of marketisation and how much risk selection and denial of care a government is prepared to tolerate in its health system.

In respect of a single tier health care system, it is important to note that there is no country in the world that has delivered universal health care through a market and for-profit provision or private insurance. This is because markets operate through selection and exclusion, transferring risks and costs back to the users of services and denying care to those that need them most. Risk selection and exclusion is built into the design of market administration; in contrast, inclusion and redistribution must be built into the systems of public administration for universal health systems. Risk selection and risk avoidance mechanisms undermine the goal of access and universality.

The US, with health expenditure of around 18% of GDP, denies more than one in five of its population access to health care. Overtreatment and denial of care, health care fraud, catastrophic costs and spiraling health expenditure are the hallmark of US health care. Those countries that have adopted the US model of mixed funding (public and private) together with public and private provision have more marketisation, higher administration costs, the greatest inequalities in access and health outcomes, lack of coverage, and highest out of pocket payments. Out of pocket payments are major barriers to access and the committee has heard evidence on the effect of out of pocket payments on patients. The European Health Observatory report into the Irish Health system reports that two thirds of the were population paying the full out of pocket costs of primary health care in 2008. It has also taken evidence from GPs involved in the Deep End Initiative about the “inverse care law” and its operation in Ireland because resource allocation does not follow need resulting in maldistribution of funds and services. According to Julian Tudor Hart,

“The availability of good medical care tends to vary inversely with the need for it in the population served. This ... operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced.”

“To the extent that health care becomes a commodity it becomes distributed just like champagne. That is rich people gets lots of it. Poor people don’t get any of it.”

The UK put in place its National Health Service in 1948, as a universal integrated public health system free at the point of delivery and funded through central taxation. Central taxation is the fairest and most efficient way of funding. The legislation and the system became the model for many countries’ health systems across the world. The UK NHS had the lowest cost, and the most efficient and fairest system, guaranteeing health care to all its citizens without fear of catastrophic health care costs or being denied care. In 2012, following two decades of market incrementalism, the government in England abolished the universal public model by abolishing the duty on the Secretary of State to

provide key health services throughout England. Instead it has made commercial contracting virtually compulsory; has introduced new mechanisms for fragmenting and dismantling care and reducing services; and has made foundation trust hospitals structurally 49% private thereby diverting their focus to private income. US inspired market risk selection mechanisms have been introduced (including the switch to membership based organisations, DSRGs, Trusts, tax breaks) with catastrophic consequences for universal public health care. Scotland and Wales have retained the universal single tier integrated public NHS model. However, the Westminster UK Treasury controls the funding through the block grant allocation which puts their systems under severe pressure. In England, 75% of foundation trusts are in serious financial deficit; in contrast, no hospital in Scotland is going to the wall. This is because hospitals and community services are integrated into and directly managed by the health boards which in turn are accountable to and responsible for local health needs.

If universal health care is the goal, we need first to understand how the principles of universal health care underpinned by public health need, redistribution, and risk-pooling or social solidarity are alienated by markets and marketisation. Second, clear and strong laws are required to enact universal health care. It has been argued that incrementalism may be the best strategy for Ireland. I disagree, the pace of change will be too slow and may go in the wrong direction: since 2008 there has been an erosion of entitlements (meanstesting of the Medical card in 2009) and an increase in the level of co-payments/charges for some services (table 4.2), notwithstanding the extension of the GP card in 2015. Of course, every country must build on existing infrastructure and take account of its own history of services development. However, all countries with an NHS have put in place a law and strong legal framework to ensure that a universal national health service happens and that parliament commits to it. This has required building a strong political consensus in order to overcome the many vested interests that would retain the fragmented, marketised, private elements and jeopardise the health of many. My understanding is that given the committee's commitment to articulating a vision of universal single tier health service, an NHS Bill for Ireland is the essential first step in the ten year plan.

If a law is enacted which commits the government to providing a universal health care to all citizens and residents throughout the land, parliament will decide how much it will spend. It is the task of the administrative bureaucracy to determine how the functions will be implemented and to ensure that resources are allocated fairly and appropriately according to needs. A bottom up approach can be adopted. Access to universal health care requires strong systems of public administration and adherence to six common principles: fairness of financing; fairness of resource allocation; risk pooling and social solidarity in service provision; political accountability and control; service integration through geographic units of administration; and public accountability through strong systems of information and surveillance systems.

As the committee has heard from the IMO, experts and other organisations, it is the primary care teams including general practitioners which are the gatekeepers to acute and specialist care and have a major part to play in prevention and rehabilitation and working with social services. A strong primary care and social care system rooted in strong information systems is essential to ensure health care for all. Primary care is seriously underfunded and under capacity and this creates pressure on acute services, social services and the family.

In my opinion a Bill to give the legal framework for a National Health Service throughout Ireland is essential and is the necessary first step towards achieving the Sustainable Development Goals for universal health care and access to rational and essential medicines.