COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Draft Budget 2011-15: Professor Charles Normand

18 January 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Draft Budget 2011-15: Briefing from Professor Charles Normand

---

18 January 2011

Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Mickey Brady
Mr Pól Callaghan
Mr Alex Easton
Mr Tommy Gallagher
Mr Sam Gardiner
Mr Paul Girvan

Witnesses:
Professor Charles Normand) Trinity College Dublin

The Chairperson ((Mr Wells):
I welcome Professor Charles Normand from Trinity College Dublin. Professor Normand, you had the advantage of seeing your colleague go first. Therefore, you know how we structure these sessions and have heard some of the questions that you are likely to be asked. Feel free to use the first 10 minutes to set the scene.

Professor Charles Normand (Trinity College Dublin):

Thank you for asking me back here. It is 29 years since I started work two floors up from this room. Those were some of the happier years of my life as a Northern Ireland civil servant.

The Chairperson:

I was here 29 years ago, too, which is frightening.

Professor Normand:

The happiest day was 24 years ago, when I left. I have taken an interest in health affairs here over the intervening period, though I worked in other jurisdictions previously and since.

The discussion between the Committee and Ciaran on the lack of detail provided was of great advantage to me. That lack of detail made my calculations much quicker, because it meant that so few were possible. I am sorry that I cannot go into more depth on some of the issues that I think are important. All I could do was reverse engineer some of the figures provided and try to work out how they had been calculated. However, without the base information, it is difficult to go much further.

However, I do not think it useful for someone in my position to try to address the question of whether current or future funding is at the appropriate level. That is a highly detailed question, and it is also a policy question as much as a technical one. However, we can consider the proposed increases as set out in the bid from the Department and look in detail at the different categories therein. We can try to pick out the extent to which those are generally inescapable pressures on costs, or the extent to which they may be amenable to good management.

The first issue is that of demographic change, which has already been discussed. It happens to be an area in which I am, of course, becoming increasingly interested. As Ciaran pointed out, I am much older than him, although older than I look. Critically, an evolving body of evidence suggests that ageing per se is of little importance, particularly in acute hospital services, and of only modest importance in continuing care. As Ciaran said, that is driven largely by the understanding that death, rather than ageing, is the problem. A number of care needs are clustered near the end of life. The most recent work, although it is still not fully published, suggests that age has almost no effect on acute hospital care per se, but that approaching death has a significant effect.

I thought that it would be useful to examine what will happen to the Northern Ireland demographic. The good news is that the population is rising and the number of people dying is falling. The situation is such that fewer people in the older categories are in the last year of life. That should create significant relief from the pressure that ageing might otherwise bring, because the numbers dying are falling, and people dying are the major drivers of the unavoidable needs for service.

There is a suggestion that, if a demographic effect is to occur, it will be significantly less than what had been suggested. That is because, as far as I understand it, the documents that I was sent suggested that, if there are 20% more people between the ages of 75 and 80 and people between the ages of 75 and 80 cost X amount, the extra cost will be X. However, that ignores the fact that the numbers of people in that category who are relatively well and not approaching death will fall rather than rise. There are good reasons to think that the demographic pressures will not be as strong as they appear in that documentation.

There is similar evidence, albeit not as strong, on long-term care. That suggests that ageing increases costs, but not in proportion to the number of people in older age groups, because the proximity-to-death effect still applies in long-term care. However, it does not apply as strongly, and, therefore, there is still some increase in costs because people are getting older. Those increases are moderated by the fact that people are healthier in old age: there are more people in the "old" categories, but people in "old" categories are slightly cheaper than they were before. I think that there is a moderating effect in that area. My guess is that, in considering the next four years, we can say that there will be, at most, modest cost pressures due to ageing.

The one particularly good piece of news is for men. It is what I call the "men are useful after all" finding, which is that there is a converging life expectancy between men and women. My paper shows that the proportion of men in each age category in the Northern Ireland population is set to rise over the next few years as a result of men starting to have a similar life expectancy to that of women.

Recent research, to which I can refer only because I know about it, rather than because it has been published, suggests that the increase in couples, which means fewer single elderly people in the older population, has had quite a significant effect. I have written about that elsewhere as the

"one brain and one body" effect: every viable household or couple must have one of each, and the brain and body can be distributed in any way between them. However, there is clear evidence that people's ability to manage outside institutional care is significantly better when there are two people in a household rather than one, even if one person in that household is significantly disabled.

A recent study across Organisation for Economic Co-operation and Development (OECD) countries found slower growth in acute service needs and long-term care needs in countries where men are ageing more rapidly. That suggests that, in each age group that is covered in my paper, the proportion of men will rise quite substantially over the next few years. Even between 2008 and 2013, there will be quite significant increases in the proportion of men in the population. Therefore, for all those reasons, the demographics are, essentially, encouraging. Fewer people are dying, and people in the older age categories are, in some senses, healthier.

Ciaran quite rightly pointed out that there is still much debate about the extent to which there is a compression of old-age morbidity, but there is some evidence of some such compression. Fewer people in the older age groups are dying, there are more men, and, therefore, more two-person households are emerging. The combination of those factors will relieve the pressure significantly. My overall view is that, over the next few years, it is unlikely that demographic pressures will be difficult to handle. We are going through a good period in which the number of deaths is falling and the number of older people is rising.

The other drivers relate to pay. I knew, with great certainty, that my salary would never be cut at any time in my life — until it happened two years ago. I am now 15% poorer than I was — not to mention the tax increases that made me 25% poorer. I knew that that would never happen, because I had never heard of a public sector pay cut in any country. However, once it happened, we realised that it could happen. The constraints on public wages and salaries in the Republic have been manifested not only in a refusal to increase wages or introduce people into the lower categories at lower salaries, but in an absolute cut of, effectively, about 15% in the salaries of public sector workers. As I said, until that happened, I had been certain that it was unimaginable and impossible.

It is interesting that, when those cuts happened, public sympathy for the public sector workers was pretty close to nil. The general public did not consider it a bad policy. Obviously, public

sector workers thought that it was a bad policy, but it was interesting that absolute pay reductions were brought in. That had the effect of significantly reducing the number of redundancies in the public sector by taking 15% off the wage bill. It facilitated a significant reduction in the cost of the services without a similar reduction in staffing. I am not suggesting that the Northern Ireland Health Service go out on a limb and introduce pay cuts; I am just saying that it happened in the Republic. One need only travel south for two hours on a train to see where it happened. When the pay cut option was compared with an equivalent reduction in the size of the public sector, it went through with relatively little difficulty.

I will respond to a basic point that was raised during the earlier discussion. The pay cuts did not stop people going up the incremental scales; the scales were simply moved down by 15%. Workers in the Republic's public sector are predominantly on incremental scales, and they still move up those scales, but those scales are now lower. Of course, as more people reach the top of the scale, that absolute decline was not being offset by people creeping up the scales.

I have a few brief comments on non-pay inflation. The purchasing power of public authorities in health services in all countries has strengthened significantly, because they have had to live in more constrained times and, therefore, to drive harder bargains. That is well illustrated by the public purchasing of drugs in the Republic. Simply by being much tougher in that process, prices were, effectively, brought down by about a quarter, albeit that that was from a ridiculously high starting point. Nevertheless, there are signs that strong purchasing has reduced the prices of the non-pay inputs into health services quite significantly. I hope to see that kind of attitude brought into any health system facing these kinds of financial constraints.

Residual demand is the difficult issue, because, having said that ageing per se has very little effect on the demand for health services, traditionally, older people were discriminated against when it came to access to care, but they are no longer keen to be discriminated against. That has been a real and extremely important source of pressure. Ten years ago, older people might have been sent home having been told that nothing could be done for them, whereas, now, they do not expect to be sent home on that basis. They expect to receive treatment.

There is quite a lot of evidence that age was used as a criterion for rationing services, even when it was not a particularly appropriate criterion for doing so. Some of the residual demands described in the Department's paper are things that probably should have happened but did not,

although they may have been higher priorities than some things that did happen. There is some difficulty in that area. I cannot, therefore, make a simple blanket statement that you do not need to go down that route.

My brother, for example, had Down's syndrome and was looked after at home. He is an example of what Ciaran referred to as people coming "out of the woodwork". When people with Down's syndrome were being moved out of long-stay institutions, it was suddenly discovered that there were already as many people with Down's syndrome outside of institutions, and they had exactly the same needs. It was difficult to resist the pressure for them to receive proper services outside, even though they had previously been looked after without those services. Some residual pressures are difficult. I cannot make any general comments about the ones to which the paper refers, because I do not know in anywhere near enough detail what is contained within them.

I will make a simple point about the revenue and non-revenue consequences of capital schemes. If a new building is erected, the old one should no longer be used. If the system is being managed well, some additional costs should be offset by savings elsewhere, unless the previous facilities were inadequate. I was on the commissioning group for the Belfast City Hospital. I was responsible for the orange cladding on the exterior, and I apologise to anyone who might have wished for a different colour —

The Chairperson:
Some of us think that it is very nice, actually. *[Laughter.]*

Professor Normand:
I did not choose the colour, only the cladding. When that building opened, we had to reduce the volume of services, because the new building was so much more expensive to run than the old buildings that it replaced. That was partly because the old buildings were too small for purpose, so the new building had to be larger to offer better services. There may be some effects of that sort, but, on the whole — I know that this is a not a very large part of the bid — new facilities are often cheaper to run, more energy-efficient and better configured.

It often surprises people that single rooms in hospitals are cheaper to run than multi-bed wards. Fewer drugs are used in single rooms, and people recover more quickly, fall less often

and have shorter stays in hospital. A well-configured building can reduce care costs, but if additional buildings are required because the previous ones were too congested, it can also potentially increase them.

I will say a few things about the potential for savings. A great deal of work is done internationally to compare the efficiency of health service delivery in different countries. On the whole, one advantage of living and working in the Republic of Ireland is that its system started off as very inefficient. Therefore, its scope for efficiency was, perhaps, greater than in some other jurisdictions. However, in general, when finances are tight, most countries can find efficiency gains of between 10% and 15% if given a year or two to do so, because, of course, the capacity to be efficient changes continually. We learn new, better and cheaper ways to do things. I would never say that efficiency gains were not available. Sometimes, however, they are difficult to put into practice.

There are, perhaps, particular difficulties in the Belfast area. I know that, as a result of previous decisions, services in the area have been put under particular pressure during the past five years. Some efficiency gains will already have been squeezed out of the system during that period. Nevertheless, I would never seek efficiency gains of less than 5% to 10% over a couple of years, simply through getting people to do things better. I will give you a simple example from when I studied cardiac surgery services at the Royal Victoria Hospital. Patients used to stay in intensive care for two days and in hospital for 12 or 13 days. Now, if a patient is in intensive care for more than six hours, people think that he or she has been forgotten and left behind. We are finding new ways of doing things that are, often, better and cheaper. Therefore, I expect some scope for efficiency savings, but some will take a little bit longer to achieve. I am sorry if I gone a little over my time, but I just warmed to my theme.

The Chairperson:
Thank you very much. Some of that was extremely interesting, Professor Normand, particularly as you gave all the male members of the Committee a great deal of heart when you told us that our life expectancy is converging with that of the ladies.

As Pól Callaghan wanted to ask a question during the previous session, I promised him that he could ask the first question, followed by the Deputy Chairperson. Pól, I will let you in immediately.

Mr Callaghan:

Thank you, Chairperson, and I will try to be succinct. I want to touch on two topics, one of which is demographics. You suggested that there is a small or negligible effect from ageing, certainly over the four-year term that we are considering. I appreciate that, in the bid document to which you and Ciaran referred, the demographic bid is not split into geriatric pressure and paediatric pressure. However, the explanatory notes state that both are included. Those notes further state that older people cost health and social care nine times as much as average people. Does that rhyme with your experience?

Professor Normand:

Yes. However, that does not mean that an increase in older people will also cost that much. The reason why it is thought that old people are expensive is that they are, typically, nearer the end of life than younger people. If we count age from when people are likely to die, rather than from when they were born, we get a much more accurate prediction of how much they will use health services. The only difficulty is that we know only after the event whether our prediction was correct.

A high proportion of people’s use of health services comes in the final three months, six months and, to some extent, year of their lives. During that period, there is a huge expansion of demand. Strong evidence from 15 or 20 countries shows that that is the case. Older people can be described as using more health services than younger people. However, as the number of older people increases, and particularly if they are not near the end of life, that has little effect on cost pressures. As I pointed out, the number of people who are dying in Northern Ireland is, thankfully, reducing quite significantly. In the next few years, therefore, fewer people will be near the end of life than in previous years. There is an absolute reduction in the number of people who are dying as well as an increase in the older population. It is doubly encouraging that there are more older people and that fewer people, in absolute numbers, are dying.

Mr Callaghan:

Your paper touched on the issue of residual demand. Ciaran’s paper pointed out that the Department’s figures seem to have been calculated on the basis of a 2·5% compound increase over the four years of the Budget. I am sorry that I did not get a chance to ask Ciaran about that earlier. I hope that he will forgive me. How do you rate that compared with other systems?

Professor Normand:

In the past, most countries looked at that level of increase as one that, essentially, accommodates things that are now useful and available that had not been so previously. We can all find examples of previously unavailable but genuinely useful treatments that are now available because of advances in technology and skills. In the past, such treatments were not a priority, because they did not exist in a useful form. We all have many examples of treatments that have become so much better that they are now worth including, whereas, previously, they were not.

The figure of 2% or 3% a year is not a bad estimate of how that rolls out. Of course, at the same time, some residual demand can be accommodated through the improvements in technique that advances in technology bring. Much more day surgery is possible, for example, because anaesthetics and some minimally invasive techniques have improved. Therefore, fewer people have to remain in hospital, because they are not as traumatised by the experience. Therefore, it works both ways. Originally, I trained as an industrial economist, and I learned that technological change only lowers cost; it never increases it. However, new opportunities increase cost if one chooses to take them. It comes back to the fact that the question is, essentially, one of policy. Do we want to improve access in those ways? If we do, we should do so deliberately and state that it is worth doing. Ciaran is much more of an expert on technology assessment. The strong assessment of new technologies to ensure that they make the grade is an extremely important part of managing residual demand and the process that leads to it.

Mrs O'Neill:

I very much enjoyed both of today's presentations. I do not want to harp on about demographic change, but I found the proximity-to-death effect that you mentioned particularly interesting. Your paper suggests that the bid could, perhaps, be more modest in that respect, but how do we measure it?

Professor Normand:

A sizeable body of literature has calibrated the extent to which increased costs are associated with being close to death. As I wrote some of those papers, I am not a completely neutral party, although nobody has challenged my findings. The answer to your question is that it is possible to calibrate the extent to which higher costs are associated with people being near the end of life, and, under those circumstances, it is possible to work out the death effect. By reducing the

number of people close to death, the proximity-to-death effect becomes doubly important, because it suggests an absolute reduction in demand coming purely from people who are in that extremely expensive stage of life.

Mrs O'Neill:

You said that, with good management, it is not unreasonable to expect the Department to find between 5% and 8% of improvements. However, the Department told us that it cannot achieve that within the period allocated. Is it unreasonable to expect the Department to find those savings in the first year of the budget?

Professor Normand:

I am old and cynical enough to think that that sort of amount can always be found without too much difficulty. I am on the board of St James's Hospital, and, this year, we face a further 8% cut in our budget. We know that that will be unachievable and that we are bound to make a loss. However, by the end of the year, as in every year, we will not make a loss, because we always just manage to make things happen. Nevertheless, at the beginning of each year, we always tell people that it will be impossible to achieve. Otherwise, they do not try hard enough. I have come to the view that a well-managed service can find those kinds of savings quite quickly, but it is not easy.

What always worries me is too much organisational change in that period. Sometimes, people decide to merge two hospitals to make savings, but it takes three to five years to make savings from a merger. It takes between three and five years to avoid things becoming worse after a merger, because it disrupts all the relationships that lead, or potentially lead, to good management. Every time that I hear calls for major reconfiguration —"Let's merge this, reduce this, abolish that to set up that" — I know that I am looking at five years of chaos. I started work at Trinity College just in time to predict the chaos that the Health Service Executive would bring, and, sure enough, it brought exactly that. People think that organisational change is the way to achieve improvements, but, almost always, it is not. It is almost always easier to make effective change by not throwing all the balls up in the air. In other words, it is easier simply to try to make the existing teams and structures work better.

It is a depressing finding for politicians. I am not being critical of politicians. I was going to say that some of my best friends are politicians, but that is, of course, not true. *[Laughter.]*

Politicians like grand schemes, but efficiency savings come from detailed, hands-on scrutiny and really working at things. It is a terrible finding, but if you want to effect rapid change, do not throw all the balls up in the air, because it will not happen.

Mrs O'Neill:

We are running out of time, but I want to pick up on what you said about good management delivering efficiency savings. One issue that the Committee constantly examines is whether our Health Service is over-managed.

Professor Normand:

I think that it is less so than in the past. It is probably over-administered and under-managed. Too little credit is given to good management in health services. The managing of hospitals and community health services is an incredibly difficult job to do well, and people who do it well make a huge difference to the ability of those at the front line to do their jobs well.

I could give a dozen examples, but one that I particularly liked recently comes from when I was working on the epilepsy service for the north Dublin area. The service could not get a room to use two days a week for its outpatient clinic, and so it had to run its outpatient clinic one day a week. Even though it was paying an extra consultant and other senior doctors to be there, there was nowhere for them work. The management was so chaotic that a space, which would have cost almost nothing, could not be found to allow the epilepsy service to be properly developed. The service also had a one-year waiting list to see a specialist. That is a simple example of how simply sorting out a situation could result in the much better use of a service.

I look forward to the posh south Dublin dinner party at which somebody will tell me that they are proud that their daughter has gone into health service management, because it has not happened yet. People will say they are proud of a daughter who is a doctor, but never of one who is a manager, but managers can make a huge difference. However, that does not mean that the historical administrative structures are always useful, because many of them have not been.

The Chairperson:

Professor Normand, you mentioned the unilateral 15% cut in pay that affected Health Service Executive (HSE) staff as well as the rest of the public sector. However, do you accept that the cut was made from an extremely high base? A recent article in the 'Belfast Telegraph' compared

Health Service and government pay here with that south of the border, and it found a huge discrepancy. If one is being paid 40% more than the person across the border, it is, perhaps, not too difficult to take a 15% pay cut.

Professor Normand:
Mortgages were of a similar scale as well, which makes it more difficult to take a cut. One reason why it was difficult to take a pay cut was that many people had geared themselves up to having equivalent spending levels. That said, you are absolutely right about the high starting point, although the pay cuts in the public sector also included people who were on much more modest pay.

Over recent years, being a senior doctor in the Republic of Ireland has been an extremely profitable business, because it has been ridiculously highly paid. I hate to say it, but being a university professor in the Republic of Ireland used to be an extremely well-paid role. It was nice while it lasted, but I found it difficult to argue against the changes, because the starting point was high, and, even at the lower level, we are still relatively well paid.

However, when the cuts were imposed, the cost of living was still high. Many people had difficulty making the adjustment simply because, if they had bought a house for €2 million, which did not mean that they had bought a particularly big house, they had an enormous mortgage to pay from a lower salary.

The Chairperson:
Did you find any evidence of problems retaining and motivating staff after the cuts?

Professor Normand:
There were no significant effects. Of course, with unemployment rising as quickly as it did, people did not leave jobs unless they were sure that they were moving into another one. Clearly, it is easier to make radical changes in tough times, because people will accept many changes that they would not have accepted in better times.

The Chairperson:
The Committee has been grappling with the issue of £55 million in the health budget for bonuses to consultants. When we raise that problem, the Department's response is that, if consultants are

not incentivised through bonuses over a five-year period, they would get on a train and go to work in the Republic. Even with a 15% cut, consultants are exceptionally well paid in the Republic. Is there any evidence that we would lose many of our top people?

Professor Normand:

There is fairly little evidence, not least because there are not many vacancies. I sit on appointment committees for new consultants at St James's Hospital, and I am not nearly as busy as I was two years ago. Some senior doctors respond strongly to financial incentives, but my experience suggests that that will not be a major problem. Some people chase the money, but, quite often, they are not those that we want to keep anyway. In Northern Ireland, a consultant, relative to the cost of living, still has a well-paid and attractive job.

The Chairperson:

The Altnagelvin situation is a wee bit more technical. As far as we know — I have received various text messages telling me to not count my chickens until they have hatched — we have received a significant promise of funding from the HSE in the Republic towards a radiotherapy unit in Altnagelvin. Brian Lenihan has frequently promised that that money is a definite. However, the Department says that it cannot go ahead with the unit because it does not have the funding to run it in year three and particularly in year four. That strikes us as an odd argument. Have you ever come across that before?

Professor Normand:

Not to any significant extent. I have been involved in a number of discussions about the current border not providing logical catchment areas for health services, which, therefore, need better configuration. It is not sensible, for example, that specialist epilepsy services for people in Letterkenny are provided in Dublin. The scope for managing services across the border is significant. That said, I cannot comment on the example that you gave. I know nothing about it, apart from having read about it in newspapers.

The Chairperson:

One point that has been made is that, at the moment, people in Altnagelvin still access that service, but they travel twice or maybe three times a week for chemotherapy or treatment in Belfast City Hospital. The new unit has been costed on the basis that the HSE will pay whatever is required for its element, as people in Donegal, Sligo or wherever will benefit. Let us assume

that we are talking about patients only from Northern Ireland: is there any logic in the suggestion that, if we build a new unit, it will cost more to run?

Professor Normand:
There is no significant logic in that. Beyond the point of needing management, clinical leads, and so on, there are few economies of scale in the provision of health services. The scope for economies of scale in health services is quite limited, and, therefore, I do not regard that as a major cost driver. However, it is sometimes difficult, because the cost must be taken off the place that previously provided the service. We have never been very good at making money follow the patient in that way.

The Chairperson:
Pól has an interest in the subject.

Mr Callaghan:
I do, both as a public representative, because I represent the Foyle constituency and because I grew up in Letterkenny. Therefore, I am conscious of the various catchment issues. It is interesting that the proposed satellite unit at Altnagelvin, at a regional level within Northern Ireland and at a cross-border regional level, is about meeting projected increase in demand as well as simply displacing the existing provision. The Minister — I am not drawing you in on the political side — said on a number of occasions that, by 2015 or 2016, Belfast City Hospital's regional cancer centre will reach capacity. Therefore, there is a slightly different dimension to what you might assume without having access to the full panoply of arguments.

Professor Normand:
Radiotherapy is one area in which where there are some economies in reaching some sort of critical mass. Beyond that, however, it is like anything else. Doubling the number of people pretty much doubles the staffing and other requirements. However, I would have to examine the specific numbers to reach a more detailed view. We plan to have two radiotherapy centres in Dublin, because there was no advantage in having only one. There were no economies of scale to merit putting all radiotherapy together on one site. It was considered just to have more locally available services.

Mr Callaghan:

May I quickly ask a general question unconnected to radiotherapy?

The Chairperson:

I will let you in, Pól, but Mickey has tabled a question for oral answer to the Minister of the Environment, although it is eighth on the list. Perhaps Leanne could keep an eye on how questions in the House are progressing. We will finish at 2.15 pm, unless another member becomes available, because we have a slight quorum problem. If Mickey has to leave, that will mean the end of the session, although we have had extremely good value for money already.

Mr Callaghan:

I want to return to the point of residual demand, as I had drawn out some points but did not pursue them. There is an important point relating to the 2·5% estimate. Professor Normand, if, as you indicate, there is an IT dividend to be gained from improvements, a 30% efficiency saving through new technology would equate to £100 million off the bid. That would not be insignificant. You suggested that Ciaran could, perhaps, do some work on that. Given that the quanta are so vast, the Committee would be grateful for any information that could be made available.

Professor Normand:

You are correct that being wrong by 1% is important, because you are dealing with small percentages of extremely large numbers. I am on the board of a hospital that spends €1 million a day. Given that large scale, being wrong by 1% turns into real money.

Healthcare is special in many ways, but it is also an industry. Most industries would expect efficiency to grow by between 1% and 3% a year, depending on the particular technology used. It is plausible that those kinds of pressures could, therefore, be largely accommodated within that sort of improvement in efficiency. We never like to point to that as a source of funding, because it is so much easier not to do it in that way.

None of us wants to be efficient. We are all in favour of efficiency for other people, but it is most inconvenient for us. When I was a civil servant upstairs in this Building, all the senior civil servants had their own dedicated secretary, which was incredibly inefficient but awfully handy, because they were always available. I had my PhD thesis typed by a secretary, because she had

nothing to do except file her nails for hours on end, and she actually wanted to work. Being efficient can, often, also be inconvenient, and we must recognise that much hard work is required to improve efficiency in any organisation.

The Chairperson:

The cost of drugs is a big issue for the Committee. There is £600 million in the health budget for drugs for hospitals and GPs. I was interested in your comment about how the authorities in the Republic were able to drive down prices. Did they drive the prices down from a ridiculous level to European and UK-wide standards?

Professor Normand:

The costs went from a ridiculous level to a fairly ridiculous level. The scope for reducing prices here would be less, because there has been a tougher regime of drugs prices here than in the South. Nevertheless, there are a few drugs nowadays for which the manufacturing cost is high, but the manufacturing cost of most is a trivial part of their price. In principle, negotiation can be effective in bringing the price down, as much of the price is, essentially, a reward for patent protection.

The Chairperson:

Some 98% of all the drugs consumed by Northern Ireland's health sector are consumed by the trusts. We have a couple of private clinics, but only a minimal number. Is there an opportunity for the Department to approach the big players and say that, because of the position in which it finds itself, it seeks serious reductions in the incoming year? Does the Department have that bargaining power?

Professor Normand:

It has some bargaining power. The bigger the entity, the more bargaining power it has. In the South, it was much easier, because there was extremely poor control before, and, from that extremely low level, the situation improved significantly. Nevertheless, as long as you are talking about a situation in which manufacturing costs are a trivial part of the price, there is always scope for good negotiation to get prices down. A slight complication here is that there is some cross-over to entities in the UK and the prices that prevail there. It may, therefore, be more difficult to run a separate regime here than it would be from the South. Nevertheless, there is always scope, particularly where there is a choice of supplier of drugs that may differ slightly but

perform similarly. For as long as there is a risk that a manufacturer will lose contracts, there is always scope for reducing prices.

The Chairperson:

Thank you very much, Professor Normand. You and Professor O'Neill received only expenses for giving up your time today, and it is greatly appreciated. I do not know the cost of your train tickets cost, but it was the best money that we have spent in a long time. We genuinely appreciate your contributions.

Professor Normand:

The cost was €41, because we travelled cattle class.

The Chairperson:

I assure you that we got our €41 worth, so thank you very much. Your evidence will be extremely helpful to us as we formulate our view on the draft budget. I, for one, will read both contributions in Hansard with great interest — I hope that the recording has not been further interrupted — because many extremely useful points came out of the session. We are extremely grateful to you both.

Professor Normand:

Thank you.