

# Challenges in Achieving Universal Healthcare in Ireland

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**BUDGET PERSPECTIVES 2017**  
**PAPER 1**

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# Challenges in Achieving Universal Healthcare in Ireland

## Abstract

The World Health Organization has advocated universal healthcare as the best means of improving global health. However achieving universal healthcare is not without challenges: from defining the goal of universal healthcare to identifying the most appropriate methods to achieve it. Ireland is unique in the EU in not having universal coverage of primary care. In 2011, a newly-elected government committed to the development of a universal, single-tier health service, to be financed by a new system of Universal Health Insurance (UHI) provided by multiple, competing private insurers. A White Paper published in 2014 outlined the proposed UHI model. However, in 2015 in response to publication of a study of the potential cost implications of the proposed UHI model, the Government abandoned this model.

This paper reviews recent policy debate on the reform of Irish healthcare; and examines how universality is defined in healthcare, the rationale for its adoption and approaches to financing universal healthcare. Building on discussion of the White Paper model of UHI and its potential cost implications, the paper examines issues that need to be addressed in any alternative system design. Using the WHO's framework for assessment of the dimensions of universal healthcare, we find that the White Paper model could have increased costs without achieving universality and equitable access. We recommend that future policy should aim to increase the dimensions of universal coverage (population coverage, services coverage and pooled payment to replace user fees), while building from the existing Irish system in the most cost-effective way possible. While acknowledging that development of a comprehensive roadmap to universality is beyond the scope of this paper, the paper explores some potential routes to advance towards universality. These are: the extension of the present tax-financed primary care system; and addressing two-tier access to hospital care by either a new public purchaser of hospital care or introducing compulsory private insurance for elective hospital care in a system designed to ensure payment according to ability to pay and Government control of insurers' margins and other costs.

## **1. INTRODUCTION**

In 2011, a newly-elected coalition government committed to reform of the Irish healthcare system, to include the development of a universal, single-tier health service, partly funded by Universal Health Insurance (UHI). A proposed model of UHI provided by multiple, competing private insurers was outlined in a White Paper published in 2014 (Department of Health, 2014). However, following the publication of an analysis of potential costs associated with this approach (Wren et al., 2015), the Minister for Health stated that these costs were 'not acceptable' although the Government remained committed to universal healthcare (Department of Health, 2015). During the general election campaign of early 2016, the Taoiseach, Enda Kenny, restated his commitment to UHI as the financing model for universal healthcare but suggested that the nature of the UHI system required further research (RTÉ Radio, 2016). The Programme for Government published by Mr Kenny's new minority Government in May 2016 did not mention UHI; however it did note that further work is required to identify the best way to finance universal healthcare (Department of the Taoiseach, 2016).

The aim of this paper is to identify and discuss the issues that arise in implementing universal healthcare in Ireland. In this analysis, we distinguish between the objective of achieving a universal healthcare system and the approach to financing this system. Whether UHI or another form of financing is adopted, the financing mechanism is only one aspect of the design of a universal healthcare system which removes financial barriers to achieving equitable access to necessary care. The next section reviews recent and developing policy debate on the reform of Irish healthcare to achieve universality. Section 3 examines how universality is defined in healthcare, the rationale for its adoption and approaches to financing universal healthcare. Section 4 discusses the White Paper model of UHI, and the methods applied in and findings from the Wren et al. (2015) UHI cost analysis. Section 5 identifies issues that need to be addressed in any alternative reform designed to achieve universality in Irish healthcare and explores potential approaches to advancing towards universality based on the existing Irish system. Section 6 concludes.

## **2. BACKGROUND**

Ireland has the only European health system that does not offer universal coverage of primary care (Thomson et al., 2012). There is evidence of financial barriers to access, unmet need for care and relatively high user charges for primary healthcare, when compared to other EU countries (O'Reilly et al., 2007; Kringos et al., 2013). Privately insured patients or those who can afford to pay privately can more rapidly access diagnostics and a first specialist appointment which facilitate speedier access to public acute hospital treatment; while such

insured or paying patients can also access the private hospital sector, which expanded rapidly in the early 2000s supported by Government subsidies (Tussing and Wren, 2006).

These and other inequities and financial barriers to access in Irish healthcare arise in a complex system, with mixed public and private financing and delivery; and multiple eligibility categories. Healthcare financing relies predominantly on general taxation, which accounted for an estimated 77 per cent of total financing in 2013, with out-of-pocket payments by individuals and private health insurance (PHI) contributing an estimated 12 and 9 per cent respectively (Wren et al., 2015). Medical cards are issued to individuals on a means-tested basis. The full medical card entitles the holder (and dependants) to free primary and public hospital services although this comprehensive eligibility was diluted by the introduction of co-payments for prescribed medications in 2010. General Practitioner (GP) services are provided in a private market, with GPs reimbursed by the state for medical cardholders' care. The 'GP Visit' medical card, introduced in 2005, entitles the holder (and dependants) to free GP visits only. In certain cases, individuals who are otherwise ineligible for a full medical/GP Visit card may be granted a card on a 'discretionary' basis, if they have particular health needs which would cause them undue hardship (HSE, 2015). Between 2001 and 2008, medical cards were also issued to all individuals aged 70 years and above: means-testing was re-introduced for medical cards for this age group in 2009 and, in a partial restoration of coverage, eligibility for GP Visit cards was extended to the non-medical cardholders in this group in 2015. Eligibility for GP Visit cards was expanded to all children aged under six in 2015. The proportion of the population covered by medical and GP Visit cards fluctuates depending on the relationship between income thresholds and the income distribution. Between 2005 and 2015, the proportion of the population covered by cards increased from 29 to 47 per cent (Wren et al., 2015; HSE, 2016).

Individuals without a full medical card or GP Visit card are required to pay the full private charge for GP services; and are further required to pay the full cost of prescription medications, with reimbursement if this cost exceeds the threshold of €144 per month (for an individual or household). Non-cardholders must also pay public hospital in-patient bed charges and self-referred Emergency Department visit charges.<sup>1</sup> Private hospital services such as private or semi-private accommodation and consultant-delivered care (purchased by private fee payment) are available in public and private hospitals for those who are willing to pay significant out-of-pocket charges but are more typically financed by private

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<sup>1</sup> ED charge is €100 per visit; public overnight charge is €75 per night up to a maximum of €750 in one year [www.hse.ie/eng/services/list/3/hospitals/Hospitalcharges.html](http://www.hse.ie/eng/services/list/3/hospitals/Hospitalcharges.html).

health insurance. In 2015, approximately 46 per cent of the population held PHI which mainly provides cover for hospital services and which is purchased largely to avoid long waits for public care (MillwardBrown, 2016).<sup>2</sup>

The 2011 Programme for Government made a historic commitment to a healthcare system ‘designed according to the European principle of social solidarity: access will be according to need and payment will be according to ability to pay’ (Department of the Taoiseach, 2011: 31). Central planks in this programme were the reform of two-tier access to hospital care and the introduction of GP care free at the point of use. The commitment of the 2011-2016 Government to re-designing the Irish healthcare system to accord with European principles of social solidarity overturned the conventional wisdom in the politics of Irish healthcare. A Labour Party policy in the general election of 2002 to remove payment at the point of use for GP services had been characterised as a ‘crazy, loony-Left’ proposal by the then Attorney General and subsequent Tánaiste, Michael McDowell (O’Connor, 2002). This not uncommon Irish perception of support for universality in healthcare as an extreme political stance rather than a European norm (Council of the European Union, 2006) can be traced to a fault line that developed in Irish health policy in 1951 when Ireland diverged from the contemporary European development of universal healthcare systems (Barrington, 1987; Wren, 2003). The then Minister for Health, Dr Noel Browne, resigned after the inter-party Government capitulated to Catholic Church and medical opposition to the removal of fees for GP care for children aged under 16 (Whyte, 1980). The first Irish Government to re-espouse this aim was the Government elected in 2011 – 60 years later.

In the decade preceding the election of the 2011 Government, the case for reforming the system of access to Irish healthcare had been researched and developed in academic studies and political parties’ policies. Evidence supporting movement from payment at the point of use to some form of pre-payment (whether financed by tax or insurance) had been presented in the work of the Expert Group on Resource Allocation and Financing in the Health Sector (Brick et al., 2010; Ruane, 2010). Constrained by terms of reference which required its recommendations to be revenue neutral, the Expert Group recommended an extension of the tax-financed medical card system to reduce the level of out-of-pocket payments for GP care and prescribed medications, with subsidies designed to favour groups on lower incomes or with particular health need (Ruane, 2010). The case for social insurance funding of a universal healthcare

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<sup>2</sup> While 51 per cent advanced the cost of treatment as the main driver for their purchase of PHI in MillwardBrown (2016), the cost of private health insurance in general exceeds the cost of reimbursed public charges, which suggests that achieving access to private care (in public or private hospitals) is the implicit driver; 58 per cent agreed with the statement that ‘Having PHI means you can skip the queues’.

system in Ireland had been separately presented and refined in a series of studies (Thomas et al., 2006; 2008; 2010).

In parallel to these academic studies, policy documents published by the two opposition parties who entered government together in 2011 had espoused variants of insurance-financed universal access to healthcare. Fine Gael policy evolved to propose a UHI model financed via competing private insurers based on the 2006 reforms in the Netherlands (Fine Gael, 2000; 2002; 2009). Labour Party policy evolved to propose a UHI model in which hospital care would be financed via multiple, largely public insurers and primary care would be financed by social insurance, with the primary care reform preceding the hospital reform (The Labour Party, 2000; 2001; 2011). The 2011 Programme for Government represented an ambiguous compromise between these two policies and interpretation of the programme created tensions within the Government (Dáil Debates, 2012; Loughlin, 2016).

Progress on reform was slow: the White Paper providing greater detail on the proposed UHI model design was published in April 2014, over three years into the life of the Government (Department of Health, 2014); while the Department of Health-commissioned study into the potential costs of this model was published in November 2015, three months before the general election (Wren et al., 2015). During this Government's term (2011-2016), the effect of the fiscal crisis on health budgets and staffing was to increase out-of-pocket payments for healthcare and rationing via public waiting lists, thereby reducing the pre-existing dimensions of universal coverage in the Irish healthcare system (Thomson et al., 2012; Burke et al., 2015). The most visible, concrete advance on the reform path mapped by the Programme for Government was the extension of free GP care to children under the age of six and its restoration to all over 70-year-olds in 2015. This age-based approach to extending eligibility for care without fees replaced the Programme's proposed gradual achievement of universal free GP care, commencing with extension of eligibility to groups with defined health needs, an approach which was informed by the Expert Group's recommendations but which had encountered legal and definitional obstacles (The Labour Party, 2011; Cullen, 2013; White, 2013). While the publication of the costs of the White Paper UHI model was greeted as evidence of the infeasibility of this financing approach and the need for further research (Department of Health, 2015; Fine Gael, 2016), there has to date been little discussion about the implications of these findings for the development of future strategies for achievement of universal healthcare in Ireland. The terms of reference of the research study, which analysed the cost implications of the model, had limited its scope: the authors recommended that before the introduction of a system of UHI, there should be further analysis of whether a proposed UHI model would improve health outcomes, achieve equity,

be cost-effective and whether its implementation would be feasible in Ireland (Wren et al., 2015).

### **3. UNIVERSAL HEALTHCARE – DEFINITIONS, RATIONALE AND FINANCING**

#### **3.1. What is Universality in Healthcare?**

Although an international consensus has developed about the merits of universal healthcare, the definition of universality can vary. The European Union (EU) has accepted ‘the overarching values of universality, access to good quality care, equity and solidarity’ as ‘the common values and principles that underpin Europe’s health systems’ (Council of the European Union, 2006: 1); while the World Health Organization (WHO) has advocated universal healthcare as the best means of improving global health (World Health Organization, 2015). There is overlap but not complete agreement between the EU and WHO definitions of universality. The EU articulates that:

*Universality means that no-one is barred access to health care; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need regardless of ethnicity, gender, age, social status or ability to pay (Council of the European Union, 2006: 2).*

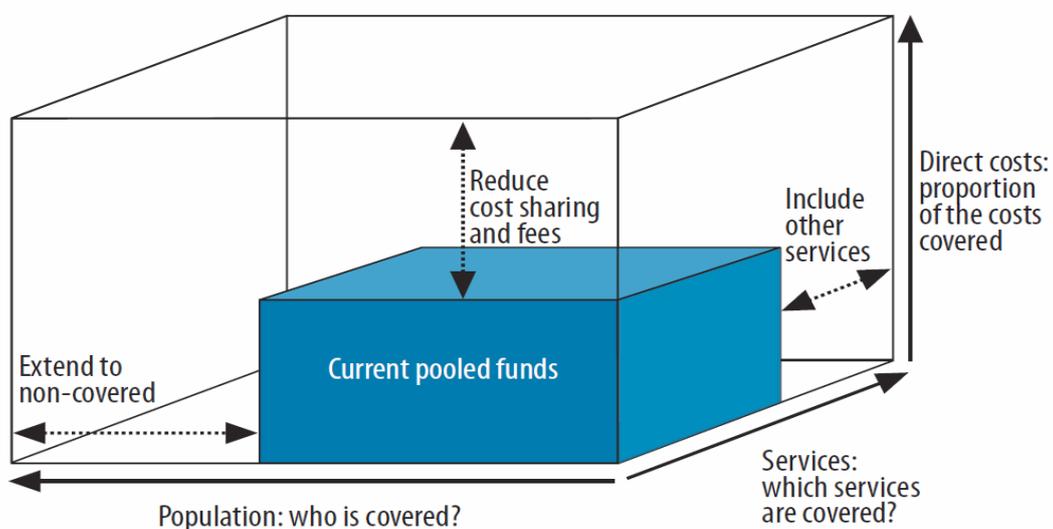
The WHO defines its goal of universal health coverage (UHC) as ‘that all people receive the quality, essential health services they need, without being exposed to financial hardship’ (World Health Organization, 2015b: iv).

The more conditional WHO definition of UHC mirrors the wording of the Irish *1970 Health Act*, which introduced the means-tested medical card scheme, with eligibility for medical cards to be limited to those who are ‘unable without undue hardship to arrange general practitioner medical and surgical services’ (Irish Statute Book: *Health Act, 1970*, Section 45). Notwithstanding this common phrasing, the values and associated ideologies informing the WHO policy and the current Irish system for non-cardholders are quite distinct. Libertarian principles, which regard access to healthcare as part of society’s reward system, are applied in the Irish system for access to primary care services by non-cardholders (Smith and Normand, 2011). In this system, health care is distributed by a private market according to willingness to pay so that individuals pay full market prices out-of-pocket for GP and other primary care services (Smith and Normand, 2011). The WHO, on the other hand, has urged countries to reduce the extent of out-of-pocket payment for health services at the point of delivery so that ‘no one should be denied health services, because they can’t afford to pay for them’ (World

Health Organization, 2015: 1). This focus on guaranteed access, with consumption of healthcare separated from payment for care, derives from the egalitarian ideologies which have informed the development of European healthcare systems (Smith and Normand, 2011) and are echoed in the 2011 Programme for Government. While some countries with systems which are regarded as universal have an element of co-payment for GP and other primary care services, these systems are nonetheless based on egalitarian principles and are thus designed to ensure access to care in need so that such payments are relatively small; while in the libertarian Irish system, non-cardholders have no protection from the prevailing market rate. Consequently, in a study of primary care in 31 countries, non-cardholders in Ireland were found to have the highest payments for GP care (Kringos et al., 2013).

Since countries which aspire to provide universal healthcare differ in the extent of universality that they achieve, the WHO has developed a framework to define and monitor the objectives and achievements of a universal system – the ‘universal coverage cube’ (Figure 1) (World Health Organization, 2010; Kutzin, 2013). First conceived by Busse et al. (2007), the cube captures a space with three dimensions: population coverage, service coverage and cost coverage. The aspiration of filling the cube as completely as possible is ‘best described by the founding principles of the British National Health Service (NHS) in 1948: “universal, comprehensive, and free at the point of delivery”’ (Busse et al., 2007: 1). As applied by the WHO, the cube identifies the proportion of the cost of services which is and is not covered by pooled funds (in effect taxation or some form of insurance) (Figure 1).

**FIGURE 1** Three Dimensions to Consider When Moving Towards Universal Coverage



Source: World Health Organization, 2010.

Within the EU, most Member States provide universal coverage (the population axis) but with fiscal pressures, some countries have lowered scope (the services axis) and depth (the cost axis), which reduces the financial protection which universality is intended to achieve (Thomson et al., 2009). The description of a system as universal might be seen as aspirational, since countries with healthcare systems sharing that description achieve varying degrees of coverage. For example, in the tax-funded systems of Denmark, Sweden and Norway, universal coverage extends to publicly provided long-term care for older people, with little co-payment out-of-pocket, whereas in many other countries, with tax or social insurance-financed universal healthcare, long-term care is subject to means-tests and there can be substantial out-of-pocket payments (Fernández et al., 2009). Meanwhile in Israel, a system of national health insurance with compulsory enrolment (introduced in 1995), performs well in terms of population coverage, but the subsequent introduction of co-payments (Rosen and Samuel, 2009) has reduced the depth of coverage.

While these countries have systems which aspire to universality, in the current Irish system, which does not aspire to universality, the practical consequence of the rejection of this European value can be seen in the relatively high financial barriers to access to GP care for a majority of the population; and in the recourse at times of fiscal crisis to measures which reduce population coverage (re-introduction of means-testing for over 70s medical cards), services coverage (restrictions to social insurance-funded dental services) and cost coverage (introduction of prescription charges for medical cardholders).

### **3.2. Why Universality in Healthcare?**

Countries adopt universal healthcare systems for a range of reasons. While proponents of universal healthcare perceive health as a value in itself (European Commission, 2013), the international consensus view of the desirability of universality in healthcare is further based on evidence about outcomes for individuals, society and the economy, with denial of access to care resulting in poorer health outcomes and a diminution in the potential of human capital. The EU recognizes health as a precondition for economic prosperity:

*Health expenditure is recognised as growth-friendly expenditure. Cost-effective and efficient health expenditure can increase the quantity and the productivity of labour by increasing healthy life expectancy (European Commission, 2013: 1).*

Universality is promoted by the WHO for the further reason that UHC 'is a powerful social equalizer and contributes to social cohesion and stability' (World Health Organization, 2015b: iv).

While it is acknowledged that health outcomes are influenced by many social, economic and genetic factors in addition to access to healthcare services (Dahlgren and Whitehead, 1991), the role of advances in medical treatment in improving human health and extending lifespan has been recognised in studies of improvements in health that have occurred over long time periods (Fogel and Costa, 1997; Cutler, 2001). Evidence of the beneficial effects on health outcomes of access to healthcare informs the support for universality of international bodies such as the European Commission and the WHO. Conversely, adverse effects on health outcomes from cost-sharing (or user fees) have been found in a number of studies (Swartz, 2010). Influential evidence that user fees prevent access to necessary healthcare emerged from the RAND health insurance experiment (HIE) in the US in the 1970s, which found that user out-of-pocket payments reduced the use of all types of healthcare services, deterring effective and ineffective treatments to the same extent (Shapiro et al., 1986) and reduced the demand for healthcare services more for low income groups, and in particular low income children (Lohr et al., 1986). These findings were subsequently replicated for other countries and systems (Kiil and Houlberg, 2014).

In Ireland, O'Reilly et al. (2007) found that in the Republic, 18.9 per cent of patients (4.4 per cent of non-paying patients and 26.3 per cent of paying patients) had a medical problem in the previous year but had not consulted the doctor because of cost; this compared to 1.8 per cent of patients in Northern Ireland, with access to care free at the point of use. While theoretically, raising the means-test income threshold and extension of cards to those with diagnosed medical need might be expected to ameliorate such effects on access in need, in practice effective implementation of such changes within the current Irish system has proven difficult. Following controversy in 2014 over the operation of the system of discretionary medical cards based on combined income and health assessments (O'Regan, 2014), the Minister for Health Dr Leo Varadkar, concluded:

*The more that I have studied the issue of eligibility for medical cards, the more I have become convinced that the only solution is universal healthcare. No matter what means-test you apply, whether financial or medical, there will always be anomalies and there will always be people just above the threshold (Department of Health, 2014b).*

### 3.3. How to Finance Universal Healthcare?

Most countries adopt some combination of the four main approaches to financing health systems: general taxation, social insurance, private insurance and out-of-pocket payments. Systems of financing universal healthcare are identified by the predominant method of financing and most commonly follow one of two approaches. These two approaches can be broadly categorized as tax-financed Beveridge systems or social insurance-financed Bismarckian systems. The Beveridge systems are named for Sir William Beveridge, author of the influential 1942 report which informed the introduction of the UK's National Health Service (NHS). The Bismarckian systems are named for Count Otto von Bismarck, Chancellor of the German Empire who introduced the first system of compulsory health insurance in 1883.

Under a general taxation, Beveridge system, everyone who pays taxes contributes to financing healthcare. Depending on the degree of universality, the entire population or segments of the population, have access to a range of publicly provided healthcare services (Gottret and Schieber, 2006). General revenues are generally the most equitable way to finance healthcare (Wagstaff et al., 1992), although the degree of equity will depend on the progressivity of a country's tax system (Chinitz et al., 1998). Advantages of using general revenues to finance healthcare include a large scope for raising resources and potential for administrative efficiency and cost control; however, the adequacy of funding may be dependent on the outcome of annual budget discussions (Gottret and Schieber, 2006). General taxation revenues are used as a source of financing to some extent in most high-income countries and may supplement social insurance financing.

Broadly Bismarckian social insurance systems finance universal healthcare in many western European countries including Belgium, France, Germany, Austria and Luxembourg. Although there is no clear definition of social insurance funding (Glied, 2008), Normand and Busse (2002) identify two crucial characteristics. First, insured people pay a regular, usually wage-based, contribution and, second, independent quasi-public bodies (usually called sickness funds) act as the major managing bodies of the system and as payers for healthcare (Normand and Busse, 2002). Otherwise, social insurance systems differ along a number of dimensions including the number and size of health funds, the system of risk equalisation, premia, ceilings on contributions, the financing of vulnerable groups, choice of provider, the mix of providers and the degree (if any) of contracting. An advantage of social insurance-based systems is that they deliver an earmarked fund for healthcare, which affords a transparent view of the link between contributions and expenditure and which may therefore enhance

support among citizens for contributing to necessary healthcare expenditures (Thomas et al., 2006).

Reliance on private health insurers as the primary vehicle for mandatory health insurance in a universal system is a feature of the system in the Netherlands, which is unusual internationally. Competing, for-profit insurers within a multi-payer system may be more cost-inflationary because marketing costs and profit drive up cost. Mathauer and Nicolle (2011), in an examination of administrative costs for social security (encompassing social insurance systems) and private health insurance schemes across high income OECD countries, found that, on average, private health insurance administrative costs were three times higher than those of social security schemes. They noted that while the rationale for competition is increased efficiency (assuming administrative costs would decrease because competition would force insurers to be more efficient in their insurance management), the level of competition is often limited so that the anticipated effect is not observed in practice. A further potential efficiency gain from competing insurers, in theory, is that competition between insurers would increase efficiency in delivery and drive down the cost of services. To achieve these efficiencies, people should be able to switch insurer with ease; competition should be based on price and quality rather than risk selection; and insurers should have access to tools that allow them to influence healthcare quality and costs and be willing to use them (Thomson et al., 2013). However, there is evidence that in the Netherlands, some of these conditions are not met (Thomson et al., 2013).

## **4. THE WHITE PAPER MODEL OF UHI**

### **4.1. Model Design**

Under the White Paper proposals, UHI would finance aspects of primary and hospital care, while programmes such as long-term and community care for older people and people with disabilities and long-stay mental health care would remain tax-financed.<sup>3</sup> Under the proposed system, every member of the population would be insured for the same package of healthcare services, with individuals purchasing insurance for this standard package from one of a number of competing health insurers (Department of Health, 2014). Financial support would be available to ensure affordability by directly paying or subsidising from taxation the cost of insurance premia for people on lower incomes. The proposed system would entail a purchaser-provider split with the purchasing of primary and hospital care largely devolved to insurers. Health insurers would purchase

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<sup>3</sup> In Ireland, no distinction is made between public health and social care programmes, which are funded from the same voted expenditure or health budget.

care for their members from primary care providers, independent not-for-profit hospital trusts and private hospitals. Insurers would be free to engage in selective contracting with healthcare providers. As part of the transition to UHI, a model for financing public hospital care based on Money Follows the Patient (MFTP) was proposed involving a shift from the current block grant budgets with minor adjustment for the volume and complexity of activity to a new system where hospitals are paid for the actual level of activity.

#### **4.2. White Paper Model, the Universal Coverage Cube and Equity**

The White Paper model was in places ambiguous and unclear so that, separate from its cost implications, its potential efficacy in achieving the egalitarian aims of the Programme for Government of access according to need and payment according to ability to pay was unclear. The unclear aspects of the White Paper proposals are obstacles to applying the WHO framework of the universal coverage cube to analyse the degree of universality in this proposed system. The White Paper stated that the Government would introduce legislation setting out

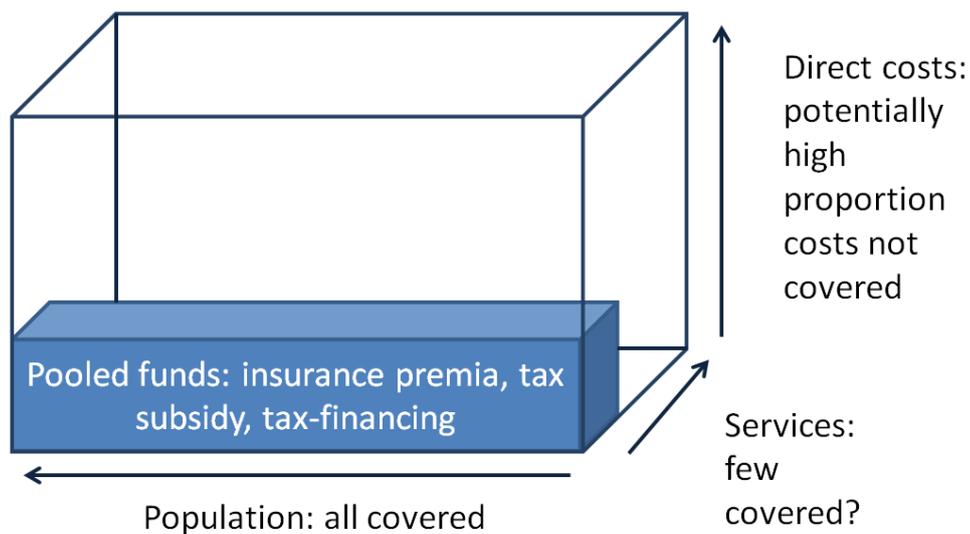
*the entitlement of every person, regardless of personal characteristics and status, to universal coverage for a comprehensive basket of health services and the obligation to contribute to the cost of services, in proportion to ability to pay (Department of Health, 2014: 8).*

However, although full coverage of the population was envisaged, the extent of services to be included in the standard insured package or basket was unclear; so that while the population dimension would be broad, the proposed dimension of service coverage could be shallow (Figure 2). Further, the extent to which out-of-pocket charges would remain was also uncertain: the Department of Health envisaged that, for instance, Emergency Department (ED) charges would remain (Wren et al., 2015). To the degree that services such as ED care or prescribed medications remained outside the insured basket and therefore outside the service coverage dimension, the current out-of-pocket payments could remain (Department of Health, 2014) so that the height of the cost coverage dimension was also uncertain.

Notwithstanding the commitment to egalitarian principles, in this proposed system design neither equity of access nor payment according to ability to pay was guaranteed. The White Paper, for instance, stated that subject to certain quality and geographic coverage rules, insurers would be free to engage in selective contracting with healthcare providers, which would allow insurers to offer different types of UHI policies, offering a greater or lesser choice of healthcare providers, and with differing levels of excess (Department of Health,

2014). The White Paper did not elaborate on how the potential conflict between these aspects of the proposed model would be reconciled with provision of equal access based on need rather than ability to pay. To the degree that this model would not achieve equitable access to the services covered by UHI, this would diminish the extent of universality in the service coverage dimension of this proposed system; to the degree that differing levels of excess (unreimbursed expenditures) would apply, this would reduce the cost coverage dimension.

**FIGURE 2** White Paper UHI Model in Universal Cost Coverage Cube



Source: Developed by authors based on Figure 1, World Health Organization (2010).

Tax-financing for the high proportion of services which were envisaged as remaining outside the UHI basket, combined with the anticipated extent of tax subsidy for the UHI system, explored in analysis by Callan et al. (2015), would have the effect that overall healthcare financing would still derive more from taxation than UHI premia.<sup>4</sup> Thus, the achievement of payment according to ability to pay would depend on the progressivity of the tax system in addition to the level of the UHI premium, the design of the subsidy system and the extent to which out-of-pocket payments would remain.

<sup>4</sup> Even in the case of the relatively more comprehensive UHI-financed Basket 3 (covering hospital, primary, and mental health care and prescribed medications) examined in the core findings of Wren et al. (2015), public current expenditure on programmes outside the UHI basket, on administration and on public pensions would account for €6.3 billion or approximately 46 per cent of the €13.5 billion Health Service Executive (HSE) gross non-capital expenditure in 2013.

### 4.3. Methods in Analysis of Potential Costs of the White Paper Model of UHI

The Wren et al (2015) analysis of the cost implications of the White Paper model of UHI necessarily adopted assumptions about a large number of the ill-defined aspects of the model: the contents of the UHI-financed basket of services; the nature of the premium and subsidy systems; the payment mechanisms for health professionals; and, crucially, the degree to which private insurers would continue to operate in a private market, governed by EU and Irish competition law. Informed by primary data analysis and the international evidence, the Wren et al. (2015) study further adopted assumptions about the dynamic effects on the behaviour of individuals and organisations of the removal of payment at the point of delivery for health services and of the purchasing of services by multiple, private insurers. Thus, assumptions were adopted about: increased service demand to meet hitherto unmet need; higher transaction costs for hospitals contracting with multiple payers; efficiency gains driven by insurer purchasing of hospital care; efficiency gains from changing skill-mix in primary care; and potential increased remuneration of GPs (Table 1).

**TABLE 1** Key Assumptions in Modelling Effects on Healthcare Expenditure of White Paper UHI Model

Scenario	Evidence	Assumed effect on UHI-financed services
Insurers' Margin	Health Insurance Authority's reports on risk equalisation (HIA, 2011; 2012; 2013; 2014)	Addition of minimum market mean margin of 7.5%; maximum 14.2%; mean 2010-2013 9.9%
Unmet Need	EU-SILC (2013) 4.8% report unmet need O'Reilly et al. (2007) 18.9% do not visit GP due to cost	4% or 10% expenditure increase
Transaction costs	Himmelstein et al. (2014) cost of hospital administration: 15.5% England; 19.8% Netherlands; difference applied to Ireland	4.3% increased hospital costs
Efficiency gains Hospitals	HIPE (2012) mean length of stay (LOS) of surgical inpatients: uninsured 7.3 days; insured 6.3 days	14% reduction surgical LOS with all patients dropping to insured mean
Efficiency gains Primary care	Cupples et al. (2008) Ratio GP: nurse visits in Northern Ireland lower than Republic of Ireland	Reduced expenditure on GP care due more delivery by nurses
Increased GP visiting	Analysis based on survey evidence (TILDA, GUI, LII) of extent of increased GP visiting when individuals no longer face fees	Increased expenditure on GP care to reimburse GPs for higher demand
GMS payments rate basis	Application variants of prevailing GP payment rates for medical cardholders to non-cardholders	Increased expenditure on GP care applying prevailing GMS rates

Source: Developed from Wren et al (2015) and further discussed in (Connolly et al., forthcoming) and (Wren et al., 2016, forthcoming).

The Wren et al. (2015) analysis adopted a societal perspective of cost: analysing the level of and sources of finance for total expenditure on healthcare in Ireland in 2013; analysing the sources of finance for services which might be financed by UHI; and then examining the effects on total and per capita health expenditure of the introduction of UHI for a range of eight potential and progressively more comprehensive baskets of services. Thus UHI-financing was substituted in this analysis for tax-financing, PHI-financing and out-of-pocket financing for services within the UHI basket, and the insurers' market margin (broadly expenses plus profit)<sup>5</sup> was assumed to apply to all UHI-financed services. This latter assumption was informed by legal advice to the Department of Health that competition law would continue to apply to private health insurers (Wren et al., 2015), notwithstanding a Programme for Government commitment that the UHI system should be designed to remain outside the competition law remit as in many European systems of statutory social insurance. The 9.9 per cent market mean insurers' margin for the years 2010 to 2013 and the top and bottom of the market mean range of those years of 7.5 and 14.2 per cent were applied in alternative scenarios in the analysis (Table 1). At the request of the Department of Health, the main findings of the analysis focused on three baskets of UHI-financed services (Table 2). A range of estimates of the effect of the proposed model on health expenditure were derived reflecting differing assumptions, with the main findings focusing on two scenarios combining assumptions of: lower or higher increases in the volume and cost of services to meet unmet need; lower or higher costs of delivery of free GP care; and lower or higher insurers' margins (Table 3).

**TABLE 2** Services in Assumed UHI-Financed Baskets in Central Findings of Wren et al. (2015)

		Basket 1	Basket 2	Basket 3
<b>Included services</b>	Hospital care	✓	✓	✓
	Mental health care	✓	✓	✓
	GP care	✓	✓	✓
	Other primary care		✓	✓
	Prescribed medications			✓

<sup>5</sup> The insurers' margin is the term used in Wren et al (2015) to describe the margin between insurers' earned premium income and their expenditure on claims incurred and is comprised of: expenses and the cost of reinsurance; and underwriting profit or loss plus the impact of investments, which sum to profit before tax.

**TABLE 3** Assumptions in Two Scenarios in Central Findings of Wren et al. (2015)

Assumptions	Scenario 1: Low Unmet Need/ Average Insurers' Margin	Scenario 2: High Unmet Need/ High GP Cost/ High Insurers' Margin
<b>Unmet Need</b>	4% increased volume and cost of services to address unmet need	10% increased volume and cost of services to address unmet need
<b>Hospital costs</b>	Increased transaction costs but efficiency gains	Increased transaction costs but efficiency gains
<b>Cost of GP care</b>	4% increase applied to cost of GP care for former non-cardholders, reflecting unmet need assumption	Higher GP remuneration
<b>Insurers' margin</b>	9.9%	14.2%

#### 4.4. Findings from Analysis of Potential Costs of the White Paper Model of UHI

The potential effect of the introduction of this system of UHI on estimated total healthcare expenditure of €19.2 billion in 2013 was found to be an increase of between €666 million to €2,055 million, or 3.5 to 10.7 per cent. This range of findings reflects the basket and the scenario adopted, with the lower end of the range applying to Basket 1 and Scenario 1 and the upper end to Basket 3 and Scenario 2 (Tables 2 and 3). These findings translate into a mean per capita UHI cost, equivalent to the mean UHI premium, ranging from €1,600 to €2,509. This range of the mean UHI premium compares to a mean PHI premium of €1,104 in 2013,<sup>6</sup> with the higher mean UHI premium reflecting the broader service coverage of the UHI basket, an increased volume of services to address unmet need and the additional costs arising from the insurance financing system. There are partially offsetting reductions in per capita tax, PHI and out-of-pocket payments for healthcare, reflecting the shift to UHI-financing for some services. The analysis does not assume a flat-rate UHI premium levied on all members of the population. Subsidies from Government to insurers for people on lower incomes would be financed by taxation (Callan et al., 2015) and the UHI premia for adults, children and students would likely differ (KPMG, 2015). In sensitivity analysis, this research found that, on most assumptions, the insurers' margin was the greatest contributor to additional healthcare costs in the White Paper model of UHI financing, with a higher assumed insurers' margin leading to higher percentage increases in healthcare expenditure. The estimated cost of the UHI model of financing (from the combination of the insurers' margin and additional transaction costs) was found in general to exceed the estimated costs to address unmet need, which would be expected to arise in a universal system, however

<sup>6</sup> The mean PHI premium is calculated by dividing total open membership undertakings' premium income by the number of people with private health insurance inpatient cover in the year from Health Insurance Authority (2015). The mean PHI premium increased from €1,008 in 2012 to €1,104 in 2013 and €1,144 in 2014.

financed. The authors acknowledged uncertainty in the unmet need estimates and recommended further research in this area.

## **5. ISSUES IN THE DESIGN OF AN ALTERNATIVE ROUTE TO UNIVERSAL HEALTHCARE**

The Government response to the publication of this analysis was that the costs of the White Paper UHI model were 'not acceptable' (Department of Health, 2015). Coming so late in the life of the Government, this rejection of the model by its proponent on cost grounds alone effectively curtailed debate on any offsetting merits that the model might have, on other deficiencies in its design or on adaptations that might reduce the costs or address other deficiencies. A case might have been made by proponents of the model that it would deliver equitable access to care and remove barriers to accessing hospital care faced by the non-insured and barriers to accessing GP care for non-cardholders. The high cost of delivering this access via multiple, competing insurers might then have been assessed relative to the achievements of these objectives. Yet, as discussed above, the achievement of equitable access and the removal of financial barriers to accessing care would not necessarily follow from this model design. The provision for selective contracting by insurers with providers and the proposed latitude for insurers to have differing levels of excess (unreimbursed expenditures) could obviate against equitable access according to need with payment according to ability to pay. Furthermore, the degree to which out-of-pocket payments for essential care could remain in this UHI system design would diminish the extent of its achievement of universality.

It appears from the deficiencies and contradictions in the design of the White Paper UHI model, that the financing mechanism had been perceived as an end in itself rather than a means to an end. Aspects of the design appear informed by a misconception that achieving universal private health insurance would be synonymous with achieving universality in healthcare. Quite apart from the expenditure implications, the continuation of features of the PHI system, such as insurers' freedom to charge differing levels of excess, for instance, are incompatible with a system designed to ensure payment according to ability to pay. The commitment to this financing model may in part have reflected a belief that it would achieve secondary objectives such as increasing efficiencies in delivery via managed competition. As discussed, the evidence for this effect of competition between insurers in the healthcare market is, however, weak (Thomson et al., 2013). It would depend on a willingness of consumers to switch insurers in response to increased premia and of insurers to contract selectively. Neither is a common feature of universal systems and both would obviate against ensuring equal access and payment according to ability to pay.

The shelving of this particular model affords an opportunity for refinement of the design of an Irish pathway to universal healthcare. In addition to committing to reaching a decision on how best to finance universal healthcare in its 2016 Programme, the new Government committed to requesting an Oireachtas All-Party committee to develop a plan for healthcare over a ten-year period, with ‘cross party consensus on healthcare planning and a shared vision’ (Department of the Taoiseach, 2016: 63). Although development of such a comprehensive roadmap to universality is beyond the scope of this paper, we now examine issues which require consideration in any alternative design. These include: the objectives of the reform; the mechanisms to be adopted to achieve the reform; the cost-effectiveness of the reform design; and the feasibility of the reform in an Irish context. We briefly consider these issues in turn.

### **5.1. Universality as an Objective of Reform**

If the objective of the reform is to achieve universal healthcare, the dimensions of the WHO universal coverage cube afford a framework in which to examine any proposed universal system. Fundamentally, such systems have in common the intent to remove financial barriers to accessing care by the creation of some form of pre-paid pooled fund or funds, which could be achieved by taxation, social insurance or, less commonly, with a central role for private health insurers. The extent of financial protection and universal coverage depends on the proportion of necessary services that are financed from the fund or funds; the breadth of population coverage; and, crucially, the degree of limitation or removal of out-of-pocket payments required to access necessary healthcare. The mechanism to pool funds – the financing mechanism – is secondary to the objective of universality in this framework. If the objective is further framed as to achieve equitable access determined by need, then complex eligibility rules and tiers are to be avoided. If payment is to be according to ability to pay, then progressive taxation or pay-related social insurance afford simpler routes to achieving this than a complex mixture of private health insurance premia, tax subsidy and general taxation.

### **5.2. Mechanisms to Achieve Universality**

The financing mechanism to achieve universality is only one aspect of the system design. Within social insurance systems, for instance, there are those with multiple insurance funds and single funds. Within tax-financed systems, there can be a single state purchaser of care (such as the HSE in Ireland) or multiple purchasers (as introduced in the UK’s NHS in the 1990s). Delivery may be largely public, largely private and is frequently a mixture. The choice of financing mechanisms or the form of delivery of care is likely to be a product of the cultural

values and historical evolution of institutions in a country. Minimising system disruption and additional cost while maximising universal coverage would be desirable criteria for the design of such mechanisms for Ireland. Universal coverage may become universal rationing, however, if supply cannot increase to meet demand, and mechanisms are therefore necessary to ensure access in need even within universal systems. These may be guarantees of access with minimum acceptable waits, supported by a fund to purchase care nationally or internationally to prevent these wait times being exceeded.

### **5.3. How to Ensure a Cost-Effective System?**

The insurers' market margin was found to be the major driver of the additional costs arising in the White Paper model. Application of the full market margin to UHI-financed expenditure was assumed in Wren et al. (2015) because of unpublished, legal advice to the Department of Health that EU competition law would apply. Yet, within the European Union, countries have implemented universal systems financed by varying mechanisms, including forms of insurance, which remain outside competition law, thereby giving government much greater control over factors such as pricing, cost control and insurers' margins. The critical distinction in ensuring that a system is outside the scope of EU competition law is that it should be designed according to principles of social solidarity with equal access to services irrespective of ability to pay (Prosser, 2010). In the design of an alternative system, such a requirement would need to be met so that an Irish Government could control costs. However, there remain challenges in ensuring that a system designed to ensure equitable access does not lose this protection from competition law requirements due to the mixed economy nature of its provision or financing (Prosser, 2010). It appears that an Irish Government intent on a major healthcare reform would be well-advised to engage actively with the European Commission to ensure parity of treatment for the new Irish system with pre-EU legacy systems, which may have remained outside the scope of EU law because they existed prior to its development.

Whatever the financing system, to ensure cost-effective delivery of universal healthcare in Ireland, payment mechanisms for professionals and healthcare providers should be designed to mitigate against supplier-induced demand (SID). Fee-for-service (FFS) payments, such as pertain in the Irish privately insured sector, incentivise the supply of more care, which may have the opposite effect to user fees, encouraging both necessary and unnecessary care (Robinson, 2001). An escalation of insured activity and cost in the rapidly growing, private insurance-financed private hospital sector in Ireland noted by McLoughlin (2014) would suggest that there should be detailed analysis of, and like-with-like comparison of, patient-level data in the private and public hospital sectors to clarify whether SID is a significant driver of private insurance costs in Ireland

before committing to a route to universal access financed via health insurers. In contrast, the current extension of access to GP care without fees, within the framework of the existing medical card system of capitation payment for GPs (supplemented by other forms of payment), is not associated with this risk.

A further consideration in designing provider reimbursement systems is to encourage providers to provide appropriate care in the appropriate setting. A capitation payment system may be associated with lower total costs than fee-for-service, because providers promote long-term preventive healthcare since additional activity represents an additional cost to the provider. Providers also have an incentive to seek alternative, possibly less expensive, providers of care, such as practice nurse substitution for GPs. However, system design must guard against the risk that capitation payment may encourage practitioners to hold larger patient list sizes in order to maximise income, which may result in a higher workload and shorter consultations (Gosden et al., 2000).

The recent publication of revised Irish healthcare expenditure data according to the definitions of the OECD System of Health Accounts (SHA), while preliminary, nonetheless suggests that total Irish health expenditure is high relative to many other OECD countries (OECD.Stat; Central Statistics Office, 2015). The reasons for this apparently relatively high expenditure require further research, examining for instance, whether the Irish system's complex combination of the privately insured sector and means-tested and rationed public sector fosters cost-inflationary features like high transaction costs and SID, which are associated with predominantly private-insurance based systems. Detailed analysis of the drivers of cost in Irish healthcare – private and public – should be a prerequisite to the design of a cost-effective universal system.

#### **5.4. Feasible Routes to Universality**

No two countries' healthcare systems are identical and a successful Irish reform is likely to have its own distinct features built on the existing system. It is noteworthy that the aspect of the 2011-2016 Government's reform programme, which advanced during its term, was the extension of free GP care, using the existing tax-financed GP Visit card system. This extension of coverage for young children will facilitate the roll out of new public health measures, such as wellness checks, at relatively low cost to the Exchequer and very low cost to Irish society, when the removal of private fees for this grouping is taken into account (Wren et al., 2015). The potential to build universal primary care from the existing tax-financed system at relatively low cost (Wren et al., 2015; Connolly et al., forthcoming) is a pragmatic argument for continuing on this tax-financed pathway, whether by progressively extending cover on age or income criteria.

The case for an alternative pathway, changing either the financing or delivery systems for primary care, would need to be supported by evidence of lower costs or greater cost-effectiveness.

Paradoxically, in hospital care in Ireland the case for universality and pre-payment has already been accepted in principle, notwithstanding the inequities in access. Public hospital care became a universal system, pre-paid by taxation, from 1979 in the case of accommodation and 1991 in the case of consultant care (Wren, 2003), albeit subsequently attenuated by overnight and Emergency Department charges. Private health insurance is a further system of pre-payment. It is the nature of the co-existence of the two systems which has created two-tier access, with the insured achieving faster access to the universal public system.

Whatever the financing mechanism, the prerequisites to develop a universal hospital care system are adequate resourcing of acute hospital care and equitable access to it. Although an argument can be made for achieving equity by introducing a purely tax-financed NHS-style system, this pathway requires a policy to address the sizeable, state-subsidised private hospital and private health insurance sectors. An alternative pathway to a system, which could reconcile tax and insurance-financing of equitable access to public and private hospital care, would be to develop the model of the National Treatment Purchase Fund purchase of private care for people on public waiting lists. In a step to universality, which would not require financing system change, this model could be expanded to a guarantee of equitable access to care with a separation of the purchaser and provider roles in the public healthcare system – a public purchaser pathway to equitable access.

Alternatively, a private purchaser pathway to equitable hospital access could be pursued in a limited and re-conceived version of the White Paper UHI model. Wren et al (2015) examined the cost of applying the White Paper model to the purchase of inpatient and daycase hospital care only in the least comprehensive of the eight baskets examined, which was not reported in the core findings of this study discussed above. On the assumptions outlined in the previous section (which may be conservative in their assessment of unmet need and which do not include an assessment of potential SID), financing these aspects of hospital care via multiple, competing insurers would add from €417 million to €741 million or 2.2 to 3.9 per cent to total healthcare expenditure. If the system were re-designed to allow control of insurers' margins, this cost would reduce. Insurers' margins on UHI-financed services, which were formerly tax or out-of-pocket financed, constitute over 60 per cent of this additional spending. The cost of such an approach to equitable access could be further reduced were it only required to

finance elective care, which is the aspect of hospital care to which two-tier access applies. Elective care is increasingly delivered via day procedures and elective discharges account for only 20 per cent of inpatient discharges from public hospitals, with the remainder arising from emergency admissions (Healthcare Pricing Office, 2014).

Since the issue of two-tier access in the Irish system arises in acute hospital care and is in essence a problem of two queues for elective care, it should be possible to design a pragmatic pathway to universality in this aspect of care, based on either a public or private purchaser pathway. Either could be founded on the existing system and tailored to address this issue of access alone, without the much wider financing shifts and risks and the institutional upheaval implicit in the White Paper model. Careful design of payment systems would be essential to avoid SID and adequate capacity would be required to address unmet need. If either pathway were contemplated, its design should of course be subject to rigorous cost-benefit analysis, which would assess the costs of the system change relative to the potential gains in health outcomes, equity and system efficiency; and relative to alternative pathways to universality.

Analysis of potential stakeholder resistance to steps on a pathway to universality such as those discussed is beyond the scope of this paper. Historically, opponents of health system reform in Ireland have included the Catholic Church and medical professionals, an institution and a professional group which have evolved beyond such monolithic opposition to change (Wren, 2003). The Irish Medical Organisation (IMO), for instance, advanced the case for a universal healthcare system in 2010 (Irish Medical Organisation, 2010). The egalitarian values expressed in the 2011 Programme for Government's commitment to social solidarity are evidence of a parallel evolution in Irish politics towards support for European values in healthcare. This commitment to social solidarity survived the change of Government, as evidenced in cross-party support for an Oireachtas Committee, to be established by a Dáil motion 'recognising... the need to establish a universal single-tier service where patients are treated on the basis of health rather than on ability to pay' (Department of Health, 2016).

This development in Irish politics appears to represent a convergence to the EU view that society, the economy and individuals gain from social solidarity in health system design. While holders of private health insurance are potential losers from a reform which achieves equitable access to public hospital elective care, unless supply is sufficient to meet demand, they are however likely to be among the potential winners from universal free GP care. If reform were accompanied by better resourced public hospitals, the insured and the uninsured

would benefit from more timely access to emergency non-elective care. Insured status is no protection from long waits on trolleys in Irish public hospital Emergency Departments.

## **6. CONCLUSION**

The historic commitment of the 2011-2016 Programme for Government in Ireland to a universal system with access to care based on need and payment according to ability to pay was not realised in many concrete achievements during the Government's term. Although coverage of GP care free at the point of delivery was extended to young children and re-instated for people aged 70 and over, other measures reduced the dimensions of universality in the Irish system. While the Government abandoned the proposed White Paper model of UHI on grounds of cost, when we assess the design of the model with reference to the WHO's universal coverage cube, we find that had it been implemented, it could have increased costs without necessarily achieving universality and equitable access.

In place of this policy which appeared to be based on a misconception that universal private health insurance was synonymous with universality in healthcare, future policy should aim to increase the dimensions of universal coverage (population coverage, services coverage and pooled payment to replace user fees), while building from the existing Irish system in the most cost-effective way possible. While acknowledging that development of a comprehensive roadmap to universality is beyond the scope of this paper, we have explored some potential routes to advancing towards universality, including: the extension of the present tax-financed primary care system; and addressing two-tier access to hospital care by either a new public purchaser of hospital care or introducing compulsory private insurance for elective hospital care in a system designed to ensure payment according to ability to pay and Government control of insurers' margins and other costs.

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