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Health Reform Monitor

The 2011 proposal for Universal Health Insurance in Ireland: Potential implications for healthcare expenditure☆

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ABSTRACT

The Irish healthcare system has long been criticised for a number of perceived weaknesses, including access to healthcare based on ability-to-pay rather than need. Consequently, in 2011, a newly elected government committed to the development of a universal, single-tier system based on need and financed through Universal Health Insurance (UHI). This article draws on the national and international evidence to identify the potential impact of the proposed model on healthcare expenditure in Ireland. Despite a pledge that health spending under UHI would be no greater than in the current predominantly tax-funded model, the available evidence is suggestive that the proposed model involving competing insurers would increase healthcare expenditure, in part due to an increase in administrative costs and profits. As a result the proposed model of UHI appears to be no longer on the political agenda. Although the Government has been criticised for abandoning its model of UHI, it has done so based on national and international evidence about the relatively high additional costs associated with this particular model.

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1. Introduction

The Irish healthcare system is a complex mix of public and private. The system is largely tax-funded, with 77 percent of total healthcare expenditure coming from general taxation revenues in 2013; 9 percent from private insurance and 12 percent from household out-of-pocket expenditure [1]. Entitlement to healthcare is subject to a complex system of eligibility categories [2]. Medical cards are awarded on income grounds, with a higher income threshold applying to persons aged 70 and over and with some (ill-defined) discretion to award cards where the absence of a card may cause undue hardship. Medical cardholders are eligible for a range of services without significant charge, although more recently prescription charges have been introduced for this group. A small proportion of those above the income threshold for a medical card are entitled to a General Practitioner (GP) visit card which provides free GP visits only. In the summer of 2015, a GP visit card was extended to all children under the age of 6, as well as those aged 70 and over. The remainder of the population (approximately 56 percent) pay the full cost associated with GP care, but are entitled to subsidised public hospital care. However, due to long waits for public hospital care, approximately 45 percent of the population purchase private health insurance, which is assumed to secure faster access.

In both primary and hospital settings, publicly financed and privately financed care is often administered by the same staff using the same facilities [3]. In primary care, all GPs work in a private market, although most have public patients (those with a medical or GP visit card) and private patients (those without a medical or GP visit card). In

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the hospital sector, there are separate public and private hospitals, but within public hospitals consultants can treat patients on a private basis [3]. Ireland has the only European health system that does not offer universal coverage of primary care [4]. There is evidence of financial barriers to access, unmet need for care and relatively high user charges in primary and hospital settings, when compared to other EU countries [4]. Private patients can achieve faster access to the public acute hospital sector. People who can afford to pay privately can more rapidly access diagnostics and a first specialist appointment which facilitate speedier access for public hospital treatment. A block grant system used to reimburse for public patients results in an incentive to treat fewer public patients as each patient represents a cost; in contrast, per diem charges for private patients provide an incentive for hospitals to treat more private patients. Similarly, consultants receive a salary for treating public patients and a fee-for-service for the treatment of private patients. These alternative payment methods for public and private patients incentivise "two-tier" access to hospital care, in which the wait time for private patients is significantly shorter [5].

In 2011 a newly elected coalition government committed to far-reaching healthcare reform for Ireland, which included the development of a universal, single-tier health service, which guarantees access to medical care based on need, not income [6]. The proposals also committed to a change to the manner in which Irish healthcare is financed, with the introduction of Universal Health Insurance (UHI). Some three years later, a White Paper was published which proposed how this reform might be achieved [7]. The White Paper provided little detail on the potential cost implications of the proposed reforms, although it was noted that spending by the State on healthcare under a single-tier UHI system should not exceed spending under the two-tier system which it replaces. Following publication of a report examining the cost implications of the White Paper proposals [1], the Minister for Health announced that "the high costs for the particular model of health insurance... are not acceptable, either now or any time in the future" [8]. In the election campaign of February 2016, the outgoing coalition government parties continued to express their support for universal healthcare but their approach to financing universality was unclear [9,10] with the Taoiseach (Prime Minister) suggesting that UHI should remain the financing model but the nature of the UHI system required further research [11]. Some opposition parties advocated tax-funded, NHS-style reforms [12]. Although the Taoiseach was re-elected to head the incoming 2016 Government, his minority government will require support from opposition deputies to pass any legislation [13]. Early signs of support for reaching cross-party consensus on a long-term approach to reform of Irish healthcare will require reconciling quite divergent views to succeed [14,15].

This paper examines the proposed reforms for the Irish healthcare system as set out in the 2014 White Paper and assesses their potential implications for healthcare expenditure in Ireland. Section 2 details differences between the current and proposed health system in Ireland. Section 3 examines how the proposed changes might influence healthcare expenditure in Ireland. Section 4 discusses the implications of health system reform in Ireland. Section 5 concludes.

2. The proposed reforms

Under the White Paper proposals, general taxation would remain as the core mechanism for raising healthcare revenues; however, UHI would finance aspects of primary and hospital care. Under the proposed system, every member of the population would be insured for the same package of healthcare services [7], though while offering some proposals in this regard, the White Paper does not identify definitively which services should be financed via health insurance. People would purchase insurance for this standard package from one of a number of competing health insurers. Financial support would be available to ensure affordability by directly paying or subsidising from taxation the cost of insurance premiums for all those who qualify. 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 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 adjustment for the volume and complexity of activity to a new system where hospitals are paid for the actual level of activity agreed.

The multi-payer, competing insurer model outlined in the White Paper is, to a large extent, based on the Dutch model of social health insurance (introduced in 2006) and marks a significant departure from the current healthcare system in Ireland. Despite this, the potential implications of the reforms received relatively little attention; perhaps because of uncertainty about the timing of the implementation of the proposed reforms as well as a lack of detail about how the proposed system would operate in practice.

A small number of studies have identified a number of potential issues that may arise if a Dutch style health system were implemented in Ireland. Ryan and colleagues, for example, noted that a successful shift to a Dutch financing system could result in a more equitable healthcare system in Ireland as it would abolish different entitlement for different groups; however, they questioned whether the Irish health system has the capacity (in terms of acute hospital beds and human resources) for the service delivery associated with such a system [16]. Similar issues were raised by Turner [17] who also questioned the affordability of premiums for those currently without private health insurance who would be obligated to purchase insurance under the proposed system.

3. Impact of the proposals on healthcare expenditure

3.1. Change in method for financing healthcare

Previous research suggests that tax-financed health systems tend to have lower levels of healthcare expenditure

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