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How changes to Irish healthcare financing are affecting universal health coverage

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ABSTRACT

In 2010, the World Health Organisation (WHO) published the World Health Report – Health systems financing: the path to universal coverage. The Director-General of the WHO, Dr Margaret Chan, commissioned the report "in response to a need, expressed by rich and poor countries alike, for practical guidance on ways to finance health care". Given the current context of global economic hardship and difficult budgetary decisions, the report offered timely recommendations for achieving universal health coverage (UHC). This article analyses the current methods of healthcare financing in Ireland and their implications for UHC. Three questions are asked of the Irish healthcare system: firstly, how is the health system financed; secondly, how can the health system protect people from the financial consequences of ill-health and paying for health services; and finally, how can the health system encourage the optimum use of available resources? By answering these three questions, this article argues that the Irish healthcare system is not achieving UHC, and that it is unclear whether recent changes to financing are moving Ireland closer or further away from the WHO's ambition for healthcare for all.

1. Background

In 2010, the World Health Organisation (WHO) published the World Health Report – Health systems financing: the path to universal coverage [1]. The Director-General of the WHO, Dr Margaret Chan, commissioned the report "in response to a need, expressed by rich and poor countries alike, for practical guidance on ways to finance health care". Given the current context of global economic hardship and difficult budgetary decisions, the report offered timely recommendations for achieving universal health coverage (UHC). This article analyses the current methods of healthcare financing in Ireland and their implications for UHC.

The World Health Report, 2010, defines UHC as "all people have access to services and do not suffer financial hardship paying for them"; it shows that nearly 34 years after the signing of Alma-Ata, major barriers to UHC still exist [1,2]. The report asks countries to address three questions in order to breakdown these barriers:

1. How is their health system financed?
2. How can their health system protect people from the financial consequences of ill-health and paying for health services?
3. How can their health system encourage the optimum use of available resources?

These questions demonstrate that the solution to UHC is not just about spending more money on healthcare but spending money appropriately.

2. Irish financial constraints

In 2008, Ireland was the first of the single European currency member states to announce that it had entered a recession [3]. This followed a high annual growth rate in

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gross domestic product (GDP) of 7.09% between 1992 and 2005. Ireland remained in recession throughout 2009 and 2010 [4,5] at which point the European Central Bank and International Monetary Fund approved a loan of €85 billion to assist Irish economic recovery. However, conditions of the loan require the Irish government to achieve a budget deficit of 3% by 2015 [6], a €15 billion budgetary saving.

Ireland is undergoing rapid population expansion and has a growing dependent population; this, alongside continuous recession between 2008 and 2010, has led to a significant rise in unemployment. Unemployment rates have risen from around 4.5% in 2007 to 14.3% in 2012 (compared to a European average of 9.7%) [3,7–9].

Ireland has a population of 4.58 million and a 1.5% to 2% per annum population growth rate [7], the major drivers of which are high fertility and,until 2009, significant inward migration. Between 1996 and 2009, Ireland experienced continuous net inward migration peaking at 105,000 in 2007 [10]. The total fertility rate in 2008 was 2.07 (2.04 in 2011), the highest of the 27 countries in the European Union (EU27), corresponding to a net increase of 45,000 people per annum. Ireland has a dependent population similar to the rest of the EU27 of 49.2%, and although Ireland has a relatively high percentage of the population aged 0–14 years and a low percentage aged over 65 years, the population aged over 65 years is projected to more than double by 2045 [8].

The combination of population expansion, growing numbers of dependents, and rising unemployment puts increasing strain on the Irish economy and subsequent healthcare financing. In 2011, a new Irish government was elected with the stated priorities to introduce free primary health care and Universal Health Insurance by 2016, both previously lacking for Ireland's 4.6 million residents [11].

3. Addressing the three fundamental WHO questions for UHC

3.1. How is the Irish healthcare system financed?

In 2011, the new government's Programme for Government committed to developing a single-tier health system of Universal Health Insurance by 2016 that does not discriminate in terms of either income or insurance status: "access will be according to need and payment will be according to ability to pay" [11]. The plan for the overhaul of the Irish healthcare system has been set out by the DoH in its report "Future Health – A Strategic Framework for Reform of the Health Service 2012–2015" [12]. The report promises to create a Health and Wellbeing Agency promoting ill-health prevention, to shift care into the community, to introduce structural reform including the dissolution of the Health and Safety Executive (HSE), and to implement significant financial reform. These changes alongside the provision of free primary health care will dramatically reshape Irish healthcare provision over the coming years with the potential to significantly widen access; however, Universal Health Insurance is still far from being in place.

Healthcare and social services provision in Ireland is currently managed by the HSE who are accountable to the Department of Health (DoH). Total public expenditure on health was estimated at just under €14 billion in 2012 from a peak of over €15.5 billion in 2009 [8].

In 2006, 78% of Irish healthcare expenditure was funded from general taxation, with out-of-pocket contributions accounted for approximately 12% of total expenditure, private insurance accounting for 8%, and social insurance for around 1%; approximately 50% of the population had private health insurance, and around two thirds made a co-payment towards public healthcare [12]. Today, out-of-pocket contributions are still required and are means tested, with medical cards being issued to those who are worst off and general practitioner (GP) cards available to those in the next income category [15]. As part of the government's commitment towards providing free universal primary care in the future, it is intended that GP cards are extended to increasingly large proportions of the population, with those with long-term conditions likely to be the first to benefit [16].

Medical cards entitle the bearer to a range of services free of charge (i.e. visiting a GP, visiting accident and emergency (A&E), hospital stays, some prescription costs, and some social care services), whereas GP cards only permit free GP visits. Those without cards have to pay for these services, for example €100 for a visit to A&E and €75 per night to stay as a hospital in-patient [15]. As demonstrated by Smith, out-of-pocket payment schemes are prone to increasing health inequities [17]; this is because among those paying for health services, the out-of-pocket payment is the same irrespective of income. Out-of-pocket payments are designed to reduce unnecessary health expenditure as well as raise money; however in the long run, overall health costs can increase as individuals choose not to access health services for non-emergency care. An example is secondary disease prevention, such as the diagnosis and treatment of hypertension, leading to poor early management followed by expensive long-term chronic disease treatment [18].

Although hospital fees are capped at €750 per year, out-of-pocket payment can be a significant barrier to accessing health services. Therefore, approximately 50% of Irish residents have voluntary health insurance (VHI) (although this contributes to under 10% of total healthcare financing) [19]. VHI is tax deductible at 20%, and 45% of VHI is provided through employment schemes, potentially leading to adverse risk selection [14]. Adverse risk selection promotes non-universal coverage and widening health inequities (those with worse health have reduced health insurance coverage). In order to counter this, the Irish government does not allow for either the exclusion of individuals or differential insurance rates to be charged based on age or pre-existing medical conditions [20].

Furthermore, as well as adverse risk selection by insurance providers, the system of voluntary health insurance is prone to adverse selection by insurance purchasers. Individuals who consider themselves to be high risk are more likely to purchase health insurance than those at low risk, meaning premiums originally intended to cover 'average risk' consumers are no longer profitable. Therefore, premiums increase causing more low risk individuals to decide not to be insured with further price increases until the high-risk patients can no longer afford cover.