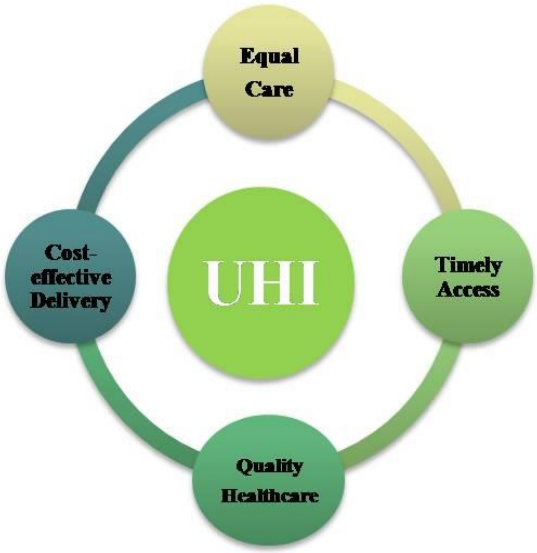
An Roinn Sláinte
DEPARTMENT OF HEALTH

Public Consultation on the White Paper on Universal Health Insurance



The information collected from the submissions made through this consultation process will be used for the purposes of informing the policy development of Universal Health Insurance. With reference to the Data Protection Act, 1988 and the Data Protection Amendment Act, 2003, the Department of Health will be producing a report on the consultation process, and information provided may be included in this report. Please note that all information and comments submitted to the Department of Health for the purpose of this consultation process are subject to release under the Freedom of Information Acts 1997 and 2003.

1 Personal Information

1.1 Are you completing this document:*

○ In a personal capacity
✓ As an authorised representative of an organisation/body, expressing the views of that organisation/body.

1.2 Name:*	**Contact: Vanessa Hetherington, Assistant Director, Policy and International Affairs, IMO**

1.3 Organisation: (mandatory if you select the second option at 1.1)	**Irish Medical Organisation (IMO)**

1.4 Please classify your organisation type: (mandatory if you select the second option at 1.1)

Trade Union and Representative Body for the Medical Profession in Ireland

○ Health Insurer or Other Insurer	○ Public Interest Group
○ Public Health Service Organisation / Provider	○ Patient Interest Group
○ Private Health Service Organisation / Provider	○ Regulatory Body
✓ Union	✓ Representative Body
○ Educational Sector	○ Other

2 Overview

The White Paper on UHI sets out the policy vision for the most radical ever reform of our health system. The major overhaul of the system will see a move away from a two-tier unequal health system to a single-tier system where access is based on need and not on income.

The key features of the UHI policy are:

- Everyone will have mandatory health insurance and their choice of insurer.
- Everyone will be entitled to the same package of care, which will include primary and acute hospital services, including acute mental health services. There will be no distinction between 'public' or 'private' patient; access to treatment will be on the basis of medical need, rather than ability to pay.
- Health services which will continue to be government funded and available outside of the UHI package include social and continuing care services, non-acute mental health services and certain social inclusion services.
- Citizens will be given a number of protections under UHI: they will be able to switch insurer annually, they will have the right to renew their policy and they will be charged the same premium for the same policy irrespective of age or risk profile.
- Citizens will also be afforded financial protection. The Government is committed to paying or subsiding UHI policy premiums for those who need support through the new National Insurance Fund.

The White Paper seeks to further develop the above features of the model by setting out a blueprint of how our future health services will be funded, organised and delivered. On that basis this consultation document sets out a number of key questions under the following four headings:

- Proposed Organisation and Delivery of the UHI Model
- Policy and Operational Aspects of the Subsidy System
- Regulation of Healthcare Providers and Purchasers
- Funding of the UHI model and the Overall Health System

You are invited to give your views, in writing, on some or all of the issues raised. Please provide your response to the questions in each relevant box. If you have no views to offer on a particular area, simply leave the box blank. There will be an opportunity at the end of this

document for other observations/comments you may have on any aspect of the White Paper or to forward an email attachment.

Thank you for giving us your views.

3 Proposed Organisation & Delivery of the UHI Model

3.1 When the UHI system is in place, health insurers will be responsible for purchasing care on behalf of the population. Do you have any views on safeguards that should be built into this system, e.g. timely access to care, geographic limits etc.?

The Irish Medical Organisation (IMO) supports the introduction of Universal Health Care and was one of the first organisations to advocate for a Universal Health System in Ireland. (See IMO Position Paper on Universal Health Coverage, 2010). However it is important not to confuse Universal Health Insurance with Universal Health Care - Universal Health Insurance (UHI) is simply a financing mechanism. Health care services are both a public good and a scarce resource. The proposed model of UHI introduces the Market Model of Healthcare (See IMO Position Paper on the Market Model of Health Care – *Caveat Emptor*, 2012) provision under which healthcare becomes a private good regulated by the state. Once healthcare is handed over to private enterprises this scarce resource becomes complex to manage and almost impossible to take back.

In 2010 the IMO set out a number of principles that should form the basis of a universal health care system regardless of the model of financing. The IMO seriously questions the ability of the chosen UHI model to deliver on

- Affordability
- Equity of Access
- Choice
- Timely Access to Care
- Quality of Care and Value for Money

Affordability

Under a market model of health care the interests of private corporations and their shareholders ultimately take priority over the provision of patient care. Costs become impossible to control as private providers and insurers vie for clients to increase turnover and market share and restrict access in order to contain costs. It is no coincidence that countries, which rely on private health insurance to fund healthcare (US, Netherlands and Switzerland) are among most expensive healthcare systems in the OECD.[1]

- In terms of health care expenditure as a percentage of GDP the US is first followed in second place by the Netherlands and Switzerland in sixth place.
- In terms of per capita spending, health expenditure is highest and more than double the OECD average in the US, followed in third and fourth place by Switzerland and the Netherlands.
- Since reform of the Dutch model in 2006 cost of healthcare in the Netherlands has been rapidly increasing. Serious questions have been raised over the sustainability of the financing system[2] and the Dutch are aiming to reduce healthcare expenditure by 20% by 2020.[3]

1OECD Health at a Glance 2013

2 Maarse H. Jeurissesn P. & Ruwaard D. Concerns over the Financial Sustainability of the Dutch healthcare System CESifo DICE Report 1/2013 (March)

[3] Source The Royal Dutch Medical Association (KNMG)

Equity of Access

The IMO believes if this system is adopted in Ireland a two-tier system of healthcare will be exacerbated and effectively institutionalised. In order to contain costs and keep with in budgetary requirements the Government will be obliged to restrict the standard basket of care and impose high out of pocket co-payments. As a result we will simply be reshuffling our two-tier system of healthcare to a system where those who can afford supplementary private health insurance will have access to a wider range of care while those without are limited to a standard basket of care with high out of pocket co-payments.

- In order to contain cost in the Netherlands the minimum basket of services covered has been gradually reduced and a mandatory deductible of €350 per annum applies to all care except GP visits. As a result the majority of people in the Netherlands (85% of the population in 2013)[4] purchase supplementary and complementary private health insurance to cover care outside the basket as well as the mandatory deductible.

Access to care can also be restricted geographically. The cost of providing care in rural and deprived areas can be significantly higher than urban wealthier areas. Market conditions incentivise health care providers to locate in areas where potential clients are both healthier and wealthier and leave deprived and rural areas under-served

- In the US large sections of the population have inadequate access to health care. About 71 million people live in areas designated by the federal government as Medically Underserved Areas (MAUs)[5] About 65 million people live in regions without adequate primary care, designated by the federal government as Primary Care Health Professional Shortage Areas (HPSAs).[6]

Choice

The IMO believes that the implications of the proposed system as outlined will restrict choice and lead to rapid closures of smaller health facilities throughout the country due to economies of scale creating additional inequity. Under the UHI system insurers will be free to vertically integrate or selectively contract with larger corporate providers in order to cut costs restricting choice to patients. The inevitable closure of smaller facilities will leave rural and deprived areas further underserved.

- Managed Care through Health Maintenance Organisations (HMO) or Preferred Provider Organisation (PPO) was introduced in the 1990s and requires patients to verify coverage with their insurer before undergoing any treatment and restricts patient choice to the HMO or PPO network.
- In the Netherlands some insurers, such as Menzis, are beginning to open their own primary-care centres to lower costs for those it insures[7] and those who purchase the

4 Dutch Healthcare Authority (NZa) Annual Statement of the Dutch Healthcare System 2013

5 Negotiated Rulemaking Committee on the Designation of Medically Underserved Populations and Health Professional shortage Areas, Final Report to the Secretary 2011 downloaded from http://www.hrsa.gov/advisorycommittees/shortage/nrmcfinalreport.pdf

6 The Commonwealth Fund, State and Federal Efforts to Enhance Access to Basic Health Care, States in Action Newsletter, March-April 2010 downloaded from http://www.commonwealthfund.org/Newsletters/States-in-Action/2010/Mar/March-April-2010/Feature/Feature.aspx

7 Daley C. Gubb J. Healthcare Systems:The Netherlands, Civitas Updated 2013

basic package can be restricted to certain hospitals or face paying between 20-50% of the bill if they choose a non-contracted hospital.[8]

Timely Access to Care

There is no guarantee that the financing mechanism can deliver timely access to care. Access to care is a capacity issue and there is insufficient capacity in the Irish health care system. Successive budget cuts over the last six years have reduced the HSE budget by over 22% or €3.3bn, staffing levels have been reduced by 10% or 12,200 WTEs since peak levels in 2007 and approximately 900 hospital beds (approximately 10%) have been taken out of the public system.[9] While efficiencies have been made and more is being done with less throughout the health system there are signs that the system is cracking under financial strain.

- In the hospital system inpatient, day case activity and emergency admissions have all increased, however HSE performance reports have shown that hospital waiting lists for outpatient and elective care are rising again as are the number of patients waiting on trolleys in Emergency Departments. The HSE budget is set to overrun again in 2014 requiring a supplementary budget before the end of the year. IMO Doctors are particularly concerned about the impact successive budget cuts have had on patient care and their ability to provide a safe service to patients under heavy financial and manpower constraints.

  Private hospitals can provide additional capacity, however private hospitals generally provide low cost more profitable elective care, while public and voluntary hospitals will continue to treat patients with more expensive complex emergency or chronic care with declining resources.

- General Practice and Primary Care in Ireland are significantly under-resourced. General Practice which is at the centre of all primary healthcare systems is now dealing with over 500,000 additional medical card and GP visit card holders with the same resources as 6 years ago. Successive cuts under FEMPI legislation has restricted the ability of GPs to provide a range of services to medical patients which to date have been provided on a pro bono basis. GPs currently provide a same-day service however free access to GP care for all without an increase in financial and manpower resources will lead to waiting lists.

  Services are being increasingly transferred from the hospital system to Primary care without the necessary transfer of resources. There is no infrastructure in place to support multi-disciplinary team working and there are insufficient community and primary care professionals to cope with current demand under the GMS. Waiting lists apply for all allied health and social care services in Primary Care and many of these services are simply not available to patients outside the GMS regardless of their ability to pay.

[8] Gowling A, Cheap Health Insurance Carries Large Risks, Dutch News

9 Thomas S. Burke S. Barry S. The Irish Health-care System and Austerity: Sharing the Pain, The Lancet 2013 Vol 383: 1545-1546

General Practice and Primary Care is associated with better outcomes, equity of access, increased patient satisfaction, more appropriate utilisation of services and long-term cost effectiveness. However the benefits can only be achieved with an increase in the proportion of funding allocated to General Practice and Primary Care services. [10]

The Government has stated that UHI must be introduced under current funding levels or less as there have been warnings of further cuts in 2015. The IMO has serious concerns about the capacity of the health care system to deliver the Government's programme of reform. Without a substantial increase in resources under UHI the IMO believe that long waiting lists will apply throughout the health system.

Quality of Care and Value for Money

There is no guarantee that a market model will deliver quality care or value for money.

- The US healthcare system has led to innovation and some care is excellent, quality of care is inconsistent and overall outcomes are poor.
- The Dutch healthcare system ranks high in terms of patient satisfaction and outcomes are good however this is a result of 30 years of investment particularly in Primary Care and not a result of the financing mechanism. Outcomes were good before the financing system was introduced. There are still wide disparities in the cost of care and little information available on the relationship between cost and quality of care.

As mentioned above the IMO have serious concerns about the impact of successive budget cuts on the quality of care and patient safety.

There is more than one system for financing healthcare and all models have their pros and cons. The IMO believe that with incremental increases in resources and careful planning the goal of universal healthcare can be delivered under an expanded taxation model or eventually under a system of social health insurance. The IMO would like to see the debate brought back to how we can best provide universal health care with open debate and consensus on the most appropriate funding model.

3.2 Do you have any views on the role of the National Insurance Fund in (a) directly financing certain services and (b) being responsible for the financial support payments system?

(a) Under the proposed system the National Insurance Fund (NIF) will be responsible for financing services outside the basket; Private Health Insurers will be responsible for purchasing care within the basket while the Health Care Commissioning Agency will have a role in establishing the amount of care to be provided by whom

10 See Kringos D.S. et al, The Strength of Primary Care in Europe NIVEL 2012

and what they are to be paid.
The IMO supports the separation of the purchaser-provider role and the introduction of money follows the patient in order to improve transparency and efficiency in the financing and provision of health care, however multiple purchasers of healthcare in the system as well as different financing mechanisms are likely to lead to further fragmentation of care in the Irish healthcare system.
The IMO submission on Money Follows the Patient highlighted the imbalances that different payment mechanisms create that need to be addressed. For example funding Emergency Department (ED) services through block funding while all other hospital care is funded through a MFTP (DRG) system can lead to insufficient funding for ED services. The MFTP (DRG) system reflect activity levels, draining funding from the rest of the health service while block funding for emergency care may be insufficient to meet demand.

(b) If this model was adopted the NIF will have a vital role providing financial support payments to those on lower incomes in the form of subsidies, but as per 4.1 below the UHI System will have limited ability to protect those on lower income from high out-of-pocket payments for care outside the standard basket or from co-payments applied to services within.

3.3 How, in your view, can integration between health services outside of UHI and those in the standard UHI package best be achieved?

As per 3.2 above with the creation of multiple purchasers of care there is a danger that care will become even more fragmented. In order to deliver on integrated care in general a wide range of issues need to be considered including:

Effective use of information,
Information and communications technology (ICT) is a key tool for supporting integrated health care systems - assisting the "seamless" transfer of patients between clinical settings and enhancing patient safety and quality of care, by reducing repetition and errors in diagnostics and treatments. In the absence of a single national system of electronic health records, the development of ICT systems in Irish healthcare is taking place in an *ad hoc* fashion. While the benefits of eHealth are considerable, these cannot be realised unless issues of interoperability, patient safety and patient confidentiality are addressed.

Appropriate standardisation of care through the use of clinical guidelines
Care pathways and clinical guidelines contribute to integrated care by standardising care across services and sites and defining roles and responsibilities for care professionals.[11] However, agreed clinical guidelines must be regularly updated to reflect international best practice and sufficiently flexible to meet individual patient needs and choices.

11 Suter E. Oelke N.D. Adair C.E. Armitage G.D. Ten key Principles for Successful health Systems Integration, Healthcare Quarterly 2009 13 Special issue 16-23

Effectively management of resources and appropriate incentivising of care providers. While it is expected that integrated care systems can lead to both administrative and clinical cost savings, integration processes may require additional initial investment before any savings become apparent. [12] Integrated care will not resolve inadequate resourcing of services nor can new activities be successfully integrated without an increase in resources[13]. Many services have been transferred from the secondary to the primary care setting without the equivalent transfer of resources and many services have never been adequately funded to begin with. The management of chronic disease in Primary Care must be costed correctly. Money must follow the patient in Primary Care and incentives must be provided for GPs to take on chronic care.

3.4 What should be the priorities for phasing the delivery of the UHI model i.e. with full implementation by 2019?

The IMO believes the priority for our health system is not the delivery of UHI but the delivery of universal health care. There are many worthy aspects of the Governments Programme of Reform for Health Services without insisting on an expensive and unworkable financing system of UHI.

The priorities over the next five years therefore should be to address the issues of capacity and access to care, inequity and the two-tier system of access to care and to ensure the long-term sustainability of healthcare services.

- A detailed implementation plan accompanied by the appropriate allocation of resources to deliver GP Care to the population which is free at the point of access
- Appropriate resources and incentives for GP management of chronic disease
- Funding for Primary Care infrastructure and services to ensure as far as possible that patients are kept out of the hospital system
- The provision of adequate financial and manpower resources to ensure the safe provision of hospital services and to deliver on the reconfiguration of hospital services.

Also that the UHI model should be implemented in such a manner to leave no shortfall in service during any periods of transitions.

12 ibid
13 World Health Organization, Integrated Health Services – What and Why? – Technical Brief No. 1. WHO Geneva. 2008 Downloaded from http://www.who.int/healthsystems/technical_brief_final.pdf

3.5 Do you have any views on the role of supplementary insurance under the new system?

As per 3.1 above in order to contain costs and keep with in budgetary requirements the Government will be obliged to restrict the standard basket of care and impose high out of pocket co-payments. As a result we will simply be reshuffling our two-tier system of healthcare to a system where those who can afford supplementary private health insurance will have access to a wider range of care while those without are limited to a standard basket of care with high out of pocket co-payments. And indeed over time the cost of supplementary health insurance may cost substantially more than current private coverage.

A concern of similar insurance based models of health care is that the amount of service provided per illness is explicitly defined based upon averages (ie 5 hours of physiotherapy post hip replacement; 5 sessions of CBT for PTSD) rather than length of treatment being defined by the individual case. This can result in those with more complex health-care needs who require greater than average input being denied necessary services than those who have less complex cases or are able to purchase supplementary insurance, thus resulting in a perpetuation different levels of care dependent upon income.

As open enrolment, lifetime cover and community rating will not apply to supplementary insurance, high risk patients will be priced out of this market further exacerbating the two-tier system.

3.6 The White Paper sets out a proposed values framework to guide the work of the Commission in assessing what services should be included under UHI and the overall health system. Do you have any views on this values framework?

In 2010 the IMO Position Paper on Universal Health Coverage set out a number of principles of that should form the basis of a universal health care system regardless of the model of financing. Those principles are:

- Access to adequate health care for all
- Services that are free at the point of access
- Equity of access
- Solidarity
- Transparency
- Quality of care and value for money
- Choice and mobility
- Clinical autonomy
- Efficiency
- Affordability
- Sustainability
-

The IMO believes that the principles of Universal Health Care should not be based around the funding model but rather the funding model should be based around the principles of equitable and timely access to all necessary healthcare.

4 Policy & Operational Aspects of the Subsidy System

4.1 Do you have any views on how the subsidy system for UHI should operate i.e. how can we ensure that it protects those on low incomes?

The IMO have highlighted in the IMO Position Paper on the Market Model of Healthcare 2012 (attached) the negative consequences of adopting such a model particularly for those on low income. Markets by their very nature favour wealthier individuals and can accentuate health inequalities. Lower income groups have shorter life expectancy and higher mortality rates. Complex health care and private health insurance is generally unaffordable for those on low income and thus requires the state to provide some type of safety net.

Under the proposed model the subsidy system it may be relatively easy to adjust subsidies to reflect the cost of health insurance premiums however the subsidy system will not be able to protect those on low income from

- **Restricted Access to Care** – The IMO firmly believe that if the proposed model is adopted, the Government, in order to maintain costs, will be obliged to restrict the minimum basket of care. A two-tier system of access to care will be exacerbated and effectively institutionalised as those who can afford supplementary private health insurance will have access to a wider range of care while those on low income will be restricted to the minimum basket of care or will be forced to pay out of pocket for this care.
- **High Out-of-Pocket payments**. The IMO also maintain that if the proposed model is adopted, again in order to contain costs, the Government will be forced to increase levels of out-of-pocket payments for care. Out-of-pocket payments are known to deter both necessary and unnecessary care and should not be applied to low income groups and those with long-term illness.
- **Risk selection by Insurance companies** No system of risk equalisation is perfect and insurance companies will always have an incentive to try and reduce costs by tailoring packages and prices to attract healthier individuals.
- **Under provision of services** Market conditions incentivise health care providers to locate in areas where potential clients are both healthier and wealthier and leave deprived and rural areas under-served.

There is more than one system of financing universal health care and the IMO believe that those on low incomes will be better protected under an expanded tax model or eventually (with careful planning and investment) under a system of social health insurance.

The system of subsidizing those on low incomes is in general a much less equitable system than one based on progressive taxation as it does not allow for adequate contributions being made by those “very high earners” who although numerically small earn disproportionate percentages of the national income.

4.2 The White Paper notes that the financial subsidy system will be provided on a means tested basis. Do you have any views on whether this assessment should be solely based on income or if other factors such as assets should also be included?

A fair system of assessment needs to include all forms of income (for example capital income such as share dividends)

4.3 Some members of the population currently have entitlements under various schemes e.g. medical cards, GP visit cards, Long term illness scheme etc. Do you have any views on how these benefits may best be delivered when UHI is introduced?

Most systems of universal health care provide a safety net for those on low income, the elderly or those with long term care needs. In Ireland this safety net is currently provided through the GMS Scheme, GP only visit card and the long-term illness scheme.

While the proposed model provides some protection for those on low income through a means tested subsidy there is currently no provision to protect the above groups from high out-of-pocket payments.

It is difficult to see how the benefits currently provided under the above schemes can be delivered without maintaining the existing or an alternative separate administrative structure. The full cost of maintaining multiple administrative and regulatory structures should be considered by the Department of Public Expenditure and Reform and the Department of Health when carrying out the costing exercise on the model of UHI.

5 Regulation of Healthcare Providers & Purchasers

5.1 Do you have any views on the proposed system of regulation of healthcare providers and health insurers? Are there any areas you would like to see strengthened?

The IMO believe that the regulatory and administrative requirements under the proposed UHI system will have significant cost implications and further drain resources from necessary patient care.

In Market-based systems require administrative staff for medical coding, claims handlers, procurement staff as well as sales and marketing personnel and advertising costs. This creates a whole level of administrative and marketing costs that are not required in other funding systems. In the US healthcare administrative costs are far higher than in any other country and American Insurers spend $606 per person[14] on administration costs alone. In addition high salaries of the top executives in private US health insurance companies can far outstrip the salaries of highly trained surgeons[15] and further drain resources from the provision of care.

5.2 Do you have any views on how the management of contractual disputes regarding health insurance might be best achieved?

In the White Paper HIQA is to take on the role of managing contractual disputes between insurance companies and providers and will have to develop specific competencies and expertise in this field. Even so it is inevitable that many contractual disputes will end up in the Courts.

This role will lead to a necessary increase in HIQAs budgeting and staffing and may both divert funds and create conflicts of interest for the Authority from its primary role of ensuring quality and patient safety within the health service.

While the management of contractual disputes is to be undertaken by HIQA, the White Paper fails to make any provision for the management of disputes between patients and insurers. A recent survey by the Commonwealth Fund of 20,000 patients in 11 countries found that one in three (32%) adults spent a lot of time dealing with insurance paperwork or disputes and were either denied payment for a claim or paid less than expected. These problems applied to one in four adults in Switzerland (25%) and one in five in the Netherlands (19%). [16]

[14] Schoen C. Osborn R. Squires D & Doty M.M. Access, Affordability, and Insurance Complexity Are Often Worse in the United States Compared to 10 Other Countries The Commonwealth Fund November 2013 published in Health Affairs December 2013 32:122205-2215

[15] Rosenthal E. Medicines Top Earners are not the M.Ds New York Times 17 May 2014 downloaded from http://www.nytimes.com/2014/05/18/sunday-review/doctors-salaries-are-not-the-big-cost.html

[16] Schoen et al 2013 opcit

5.3 Do you have any views on what economic regulation mechanisms should be applied to ensure good governance and financial management of health services?

Good governance and financial management of our health services is necessary to ensure transparency, efficiency and value for money. Important lessons must be learnt from the UK Public Enquiry into the Mid Staffordshire NHS Foundation Trust[17] to ensure that governance and financial management is fit for purpose and does not impact negatively on patient care.

Also good governance must ensure that agencies which are charged with maintaining standards regarding quality and safety of service should not be involved in regulating the commercial activity of the service.

17 Frances R. QC Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013

6 Financing of UHI and the Overall Health System

6.1 Do you have any views on the proposed new financing model for UHI i.e. a blend of premium income, direct taxation and out of pocket payments?

As per 3.1 above.

The IMO does not believe that proposed financing model for UHI which is based on the Dutch model of financing healthcare through competing private health insurers is the most sustainable or cost-effective model to adopt in Ireland

- Since reform of the Dutch model in 2006 cost of healthcare in the Netherlands has been rapidly increasing. The increase in cost has been attributed to the increase in supplier induced demand from Independent Treatment Centres (these are private centres which specialise in low cost more profitable outpatient procedures).

- The Dutch model is now one of the most expensive health systems in the OECD. Health expenditure in the Netherlands ranks second in terms of % of GDP and fourth in terms of per capita spending. Serious questions have been raised over the ongoing sustainability of the financing system and the Dutch are aiming to reduce healthcare expenditure by 20% by 2020.

- In order to contain cost in the Netherlands the minimum basket of services covered has been gradually reduced. As a result the majority of people in the Netherlands purchase supplementary private health insurance.

- The Dutch system performs well in terms of quality of care and patient satisfaction however this is the result of 30 years of investment in healthcare and not the financing mechanism. Quality of care was already high before the 2006 reform.

Under the proposed system individuals will be responsible for purchasing health insurance premiums and there is no onus on employers to contribute to the cost. For those who will not be entitled to a subsidy health insurance mandatory UHI may be seen as a personal tax to fund the shortfall in current funding. Disposable income has fallen dramatically over the past six years and the burden on households and particularly families may be considerable. There is a need to share the tax burden more proportionately across the whole economy.

Out-of pocket payment are regressive and inequitable as a means of raising funds for health care as they apply only to sick people at the point of use. See 6.2 below.

The IMO believe that with incremental increases in resources and careful planning the goal of universal healthcare can be delivered under an expanded taxation model or eventually under a system of social health insurance.

6.2 Do you have any views on the use of co-payments for services?

Out-of-Pocket payments for care are generally used to raise revenue for the health system, reduce unnecessary demand or to direct people to the most effective care.
Co-payments for health care have been found to have limited use in achieving policy objectives. Out –of –pocket payments are highly regressive and place unnecessary burden on lower income groups they are also highly inequitable as they apply only to sick people at the point of use. While co-payments can be used to direct patients to more effective care they must be applied with caution as they are known to deter both necessary and unnecessary care and should be applied with caution.

The IMO have been consistently highlighting the growing levels of co-payments that currently apply throughout the Irish health care system and their impact on access to healthcare.

Co-payments may lead to a creation of a two tier service with those not being able to fund them having either restricted or delayed access to health care.

6.3 Do you have any views on the cost control measures that have been set out in the White Paper? Are there other cost control measures that could be implemented?

The White Paper sets out a number of core measures to control costs and a second set of reserve measures to be set out in legislation but only implemented as required.

The IMO would have serious concerns about the ability of such measures to control costs.
So far the Government have had little success in containing the cost of private health insurance in Ireland. Since 2007 average private health insurance premiums have been increasing at a rate of 10% per annum.

While 3% of cost increases can be attributed to an ageing population and to the effects of adverse selection,[18] the Consultative Forum on Health Insurance has had little success in reducing health insurance cost despite introducing a range of similar measures to contain costs.

The IMO also believe that the reserve measures, which involve capping of insurers overheads, profit margins and claims expenditure, if implemented private insurers may no longer see the benefit in remaining in the market and may potentially exit having reaped the benefits for a period. Although it is questionable whether Government will legally be able to cap the profits of private insurers. The Transatlantic Trade and Investment Partnership which is currently being negotiated between EU and US, US companies may be able to sue the State for any new laws which affect their profits.[19]

The IMO believes that under the proposed UHI system the government will be forced to use alternative measures to contain costs such as reducing the basket of services or increasing the level of out-of-pocket co-payments.

[18] Sloyan L. HIA Health Insurance regulation, Presentation to the 10 National Health Summit 19 February 2014
[19] http://europa.eu/rapid/press-release_IP-14-292_en.htm?locale=en

6.4 In your view, how best can the regulatory systems set out in the White Paper provide the state with sufficient means to safeguard the financial sustainability of the health system and secure ongoing affordability of UHI policy premiums?

There is no guarantee that the regulatory systems set out in the White Paper can provide the state with sufficient means to safeguard the financial stability of the health system and secure ongoing affordability of UHI policy premiums.

Healthcare is a scarce resource and a market model increases both public demand and supplier induced demand for services in favour of those who can afford them.

There is a need to increase resources for public healthcare however resources must be targeted at those who need them and not just those who can afford them.

6.5 Do you have any views on how the regulatory and administration costs of the system might be minimised?

The regulatory and administrative costs of the system are so cumbersome and will further drain funds from an already under-resourced healthcare system. In the US administrative costs in the private health insurance sector are over 3 times higher than in the State provided Medicare and Medicaid systems. The estimated Billing and Insurance-Related Costs represent 12.3% of costs for private insurers as opposed to 3.5% in the Public Programs.[20]

[20] Institute of Medicine (US) Roundtable on Evidence-Based Medicine; Yong PL, Saunders RS, Olsen LA, editors. The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington (DC): National Academies Press (US); 2010.

7 Additional Comments / Observations

Should you wish to provide comments on any other aspects of the White Paper please do so in the box below or attach a document in the email response.

The IMO has concerns about the creation of an Insolvency Fund. Essentially a proportion of health care expenditure is to be set aside from providing care to this fund. Under a system that did not rely so heavily on private providers this money would be used for the provision of healthcare.

As stated in 3.1 The IMO supports the introduction of Universal Health Care, however the proposed financing model of UHI introduces the Market Model of Healthcare and the IMO seriously questions the ability of the chosen model to deliver on

- Affordability
- Equity of Access
- Choice
- Timely Access to Care
- Quality of Care and Value for Money

There is more than one system for financing healthcare and all models have their pros and cons. The IMO believe that with incremental increases in resources and careful planning the goal of universal healthcare can be delivered under an expanded taxation model or eventually under a system of social health insurance. The IMO would like to see the debate brought back to how we can best provide universal health care with open debate and consensus on the most appropriate funding model.

Please find attached the IMO Position Papers on Universal Health Coverage 2010 and the Market Model of Healthcare – *Caveat Emptor* 2012.