IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Position Paper on

Universal Health Coverage

April 2010

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Mission Statement

The role of the IMO is to **represent** doctors

in Ireland and to **provide** them with all relevant services.

It is committed to the **development** of a caring,

efficient and effective Health Service.

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Universal Health Coverage

With mounting pressure on the health care budget, due to the global downturn and demographic change, the fear of lack of services has pushed debate on universal health insurance firmly onto the public agenda. Government policies encouraging the development of private hospitals and private health insurance have sparked fears that health care in Ireland may be steering toward the US model rather than the European model. In the US, health expenditure per capita is double that of France and Germany and prior to recent reform almost 15% of people were unable to afford health care.[1]

Increasingly the Dutch model of health care funding is coming to the forefront of debate as a viable alternative that could build on our existing private health insurance market. However it is important to note that the Dutch system is a "work in progress". Reform in 2006, which introduced mandatory private health insurance and managed competition between insurers, was the latest stage in a process which began back in 1986. Further changes to the system have yet to come which include increasing competition between providers and increasing the ratio of health insurance funding to tax funding. Concerns have been raised already about equity and affordability for lower income groups as well as the costs of administering a complex risk equalisation system.

Whatever changes are introduced to health coverage in Ireland, the process by which change is brought in must include:

- Informed public debate;
- Consultation with all relevant stakeholders, including patients and doctors;
- Detail of the proposed model including funding sources;
- Analysis of current and future manpower resources needed for implementation;
- A realistic time table for implementation.

There must be widespread support and commitment to a model that will last over time regardless of political agendas. Therefore the advantages of any new system as well as the time and resources needed to implement change must be clearly communicated to the public.

Healthcare Financing in Ireland

In 2007, in terms of health expenditure per capita Ireland ranked just above the OECD average, with spending of 3,424 USD (adjusted for purchasing power parity) compared with an OECD average of 2,964 USD.[2] In real terms, health spending grew by an average of 6.4% per annum between 2000 and 2007. This was the third fastest growth rate of all OECD countries and significantly higher than the OECD average of 3.7% per annum.[3]

Financing and Coverage

Ireland's health care system is financed primarily through taxation including an income related health levy. According to the most recent WHO statistics for 2006,[4] 78.3% of health expenditure is funded by government revenue. Out-of-pocket payments represent about 12.5% of expenditure and private health insurance around 8.5%.

1. OECD, Health Data 2009
2. ibid
3. ibid
4. WHO World Health Statistics 2009

Recipients of healthcare can be split into two categories based on ability to pay and other criteria.

Category I - General Medical Scheme

The first group which represents approximately 35.5% of the population (1.5million people) are covered by the General Medical Services (GMS) scheme also known as the Medical Card. Under this scheme low income groups and approximately 90% of the population over 70 years old are entitled to a wide range of services free at the point of use. Services include access to public hospital services, GP services, prescription medicines (subject to a 50c co-payment per prescription item in 2010), and certain dental and ophthalmic services but exclude long-term care. In the current economic climate the HSE expects the number of medical card holders to increase to 1.622million in 2010.[5]

Category II – Population Subject to Co-payments

The remaining two-thirds of the population have access to public hospital services (subject to a user charge of 100 per day), must pay out-of-pocket for GP services (unless they qualify for a GP card) and prescription drugs (up to a maximum of 120 per month in 2010). This second group must also pay out-of-pocket for dental and ophthalmic services with limited help given through the Treatment Benefits scheme.

Safety nets: The income threshold to qualify for a GP card is 50% higher than the threshold for a medical card and support is also given for pharmaceuticals and appliances for those qualifying under the Long-term Illness Scheme and the High-tech Drugs Scheme. Some tax relief is available on out of pocket medical expenses and on health insurance premiums.

Private Voluntary Health Insurance

Approximately 52% (2.3 million)[6] of the population purchase private voluntary health insurance which plays both a supplementary role - offering faster access to care along with access to private sector care, and a complementary role - reimbursing inpatient cost-sharing and limited reimbursement of outpatient and GP visits.

Three private health insurance companies operate in a heavily regulated market with the VHI, a semi-state insurer, dominating 70% of the market.

Around 24% of the population or 1 million people are neither covered by a medical card nor private health insurance,[7] and 5% are covered by both.

Pooling

General taxes and the income-related health levy are collected by the Department of Finance. The overall budget for health is voted on annually in the Dáil. Healthcare policy and expenditure is governed by the Department of Heath and Children and administered by the HSE. The HSE distributes funds in three categories: acute hospitals,

5. HSE National Service Plan 2010
6. HIA Annual report 2008
7. Health Insurance Authority and Central Statistics Office

community and long-term care, and public health. This is then distributed at regional level along these three pillars without any overall regional financial planning.[8]

Purchasing

Physicians

General Practitioners are generally self-employed and those who hold contracts under the GMS scheme are paid by a mixture of capitation fees and fees for service. Most GPs conduct private practices, even when members of the GMS, and charge on a fee for service basis.

Hospitals

The majority of hospitals are public hospitals run by the HSE or voluntary not-for-profit hospitals run by religious orders or independent boards/trusts.

Annual hospital budgets are allocated at the previous year's level with minor adjustments for inflation and some measure of output, but with no real assessment of the number of patients who will require treatment.[9] 20% of beds in public hospitals are allocated to private patients who are charged average per diem treatment rates depending on hospital category.

Hospital based doctors are salaried. Depending on their contract some consultants can treat private patients in public hospitals on a fee for service basis.

Private hospitals are entirely run by private organisations and also charge private patients on a fee for service basis.

Issues and Challenges Facing the Irish Health System

Despite the increase in public health care expenditure Ireland's health system faces a number of issues and challenges including access to services, inequity and sustainability.

Access to Services

The current system of funding the health service delivers little additional output or service for the extra billions spent. Rather than investing in capital projects, funds have been diverted to meet demand for frontline services. As a result, per capita rates of hospital beds and diagnostic equipment are well below OECD averages[10] and waiting lists exist for elective care and access to diagnostics.

The National Treatment Purchase Fund (NTPF) which purchases medical and surgical procedures from the private sector has failed to reduce waiting times. Often the only way to access public hospital services is through the Emergency Department which, as a result, suffers from overcrowding with patients waiting hours on hospital trolleys until a bed becomes available.

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8. OECD 2008, OECD Public Management Reviews: Ireland - Towards an Integrated Public Service, p283
9. ibid
10. 2.7 acute hospital beds per thousand population in 2007 compared to an OECD average of 3.8 and 8.5 MRI units and 14.3 CT scanners per million population in 2007, Ireland compared with OECD averages of 11 and 20.2, respectively. Source OECD Health Data 2009

Due to failure to invest in primary and community based services and long-term care facilities, many elderly patients spend prolonged periods inappropriately in acute hospital beds ill-suited to their social and medical needs. The HSE reports shortages of community health workers, physiotherapists, occupational therapists, psychologists as well as suitably trained domiciliary care workers and discharge delays from hospital due to patients requiring appropriate rehabilitation services or access to a public long-term care bed.[11]

Inequity

Ireland's health system is unequal. Policies promoting private hospital care and private health insurance have created a multi-tiered system.

Because of dissatisfaction with the public system, over half the population feel compelled to purchase private health insurance principally for quicker access to elective care and also to avail of a wider choice of providers. As cost-sharing in the public system increases, healthcare is gradually becoming unaffordable for lower income groups that are neither covered by private health insurance nor a medical card.

The result however is a multi-tier system where the richer echelons of society who can afford private health care are assessed and treated rapidly while those without wait inordinate lengths for both diagnosis and treatment with some in the later group forced to pay out-of-pocket contributions towards their care while others are not.

While private patients provide extra revenue for the public system, almost half of private patients in public hospitals cannot be charged because they are accommodated in a bed that is allocated to public only patients.

Sustainability

Like our European counterparts, Ireland's health care system faces the challenge of adapting an ageing population, higher levels of chronic disease, developments in medical technologies and changes in the delivery of services.[12]

Currently 11% of the population are over 65, by 2036 25% of people living in Ireland will be over 65.[13] Elderly people can be higher consumers of healthcare as chronic illness such as cancer, cardiovascular disease, diabetes and mental health problems usually occurs in older people. Approximately three quarters of people over 75 years have at least one chronic condition and over a third of men over 60 years have two or more chronic diseases. According to the Department of Health and Children, with Ireland's ageing population and if current disease trends continue, bed requirements will increase by 50-60% over the next 15 years.[14]

New technology is a major force driving change in hospital practice and the wider health system.[15] As a result of new technology hospital care is becoming more specialised. Advances in diagnostic and screening technology are leading to earlier interventions and developments in pharmaceuticals and monitoring of chronic disease means more patients can be treated in a community based setting. While new technology can bring savings, there is a requirement for initial investment and the reallocation of resources to the right setting.

11. HSE Performance Report, March 2009…p28
12. B. Rechel, S. Wright, N. Edwards, B. Dowdeswell, M. McKee 2009, Investing in Hospitals of the Future, European Observatory on Health Systems and Policies…p19
13. HSE Health Forum Steering Group 2008 Toward an Integrated Health Care System or More of the Same
14. Department of Health and Children (DOHC), 2008 Tackling Chronic Disease: A Policy Framework for the Management of Chronic Diseases…p12
15. B. Rechel et al 2009 Investing in Hospitals of the Future…p8

Health Funding Reform

In the current economic climate, public funding is already inadequate. In order to keep within budgets, services are rationed and public clinics are often closed for a period to keep costs down which further lengthens waiting lists.

With increasing costs and public dissatisfaction with the system, the current model of funding healthcare is unlikely to hold into the future. Options for increasing funding include:

- Expanding the existing tax system
- Introducing universal health insurance
- Increasing the use of private funding

In order to tackle long waiting times in Emergency Departments, waiting lists for hospital services and to eliminate the unfair and inefficient public/private divide, Fine Gael have recently proposed a model of health reform based on the Dutch model of financing healthcare through mandatory private health insurance and managed competition between insurance companies. The Labour Party, since 2001 have proposed a Social Health Insurance model as an answer to inadequate resources, unequal treatment and ineffective management.

While the Expert Group on Resource Allocation and Financing in the Health Sector has been established to examine current resource allocation arrangements and recommend appropriate changes including the most appropriate financing mechanism, Government policy is actively increasing the use of private funding.

- Co-payments for hospital services and pharmaceuticals have been gradually increasing with each budget. A charge of 50c per prescription item under the GMS and Long-term Illness Schemes is to be introduced in 2010. While the charge is low the IMO believe it will be increased in the future;
- Hospital capacity is being increased essentially for private patients through the co-location of private for-profit hospitals on public hospital sites;
- Services are increasingly being transferred from secondary to primary care settings without the equivalent transfer of public funds and to where the majority of services are paid for privately;
- With the introduction of the 'Fair Deal' Nursing Home Support Scheme in October 2009, nursing home subventions have ceased and long-term institutional care is now to be financed through private savings accounts and other personal assets including an individual's home.

Increased use of private funding is likely to reinforce inequalities in the health care system, however there are indications that public opinion is shifting in favour of increased equality and that people would be willing to pay higher taxes (or social insurance contributions) in return for improved public services.

Principles of a Future Universal Health Care System

The IMO is committed to a universal healthcare system that aims to secure access to adequate quality healthcare for all when they need it and at an affordable cost. The following are some broad principles that should form the basis of a universal health care system regardless of the model of financing:

Universality - access to adequate healthcare for all

All residents in Ireland should have access to appropriate 'promotive, preventive, curative and rehabilitative healthcare' [16]. This means that all residents should be entitled to medically necessary care including hospital and GP services as well as services such as public health services and long-term care services which are ill-catered for under traditional social health insurance models.

Universal health coverage on its own cannot resolve the issue of access to services. The public hospital system is already a universal system but is overstretched. Substantial capital investment and manpower resourcing is required to put the necessary services in place in all healthcare settings.

Health services that are free at the point of access

All residents in Ireland, not just medical card holders, should be entitled to medically necessary healthcare that is free at the point of access.

This means that payment must pass directly from the payer to the provider. While this is more easily done under an expanded tax-funded model, it is also possible under a social health insurance model, if the insurer or sickness fund pays the provider directly without the patient paying costs upfront.

Equity of access

Access to services must be based on medical need only and not on ability to pay or any other criteria including place of residence or age.

Patients will not be able to purchase health insurance in order to side-step waiting lists. Regional disparities in the provision of services and the under resourcing of community or long-term institutional care for the elderly must be tackled so access to healthcare is equal across the country as well as across age groups.

Solidarity

A universal health system requires a degree of social solidarity where healthy people subsidise the sick and the rich subsidise the poor. The funding system must be progressive – that is based on ability to pay. The State must provide a safety net so that healthcare is affordable for low-income groups and individuals with higher medical needs.

Solidarity is easier to achieve in a tax-based system or a social health insurance system where there is a single payer. In a system of competing health insurance companies or funds strict legislation is required to address market failures including community rating, open enrolment, minimum benefit and lifetime cover.

16. WHO Achieving Universal Health Coverage: Developing the Health Financing System Technical Briefs for Policy-Makers No. 1 2005

Transparency

The public should be able to see clearly what they are paying towards healthcare and what they are receiving in return, thus allowing people to make a better judgement on whether they are receiving value for money or not. The health services that patients are entitled to should be clearly defined. Decisions concerning public funding should be made in an open and transparent manner.

Social health insurance models are traditionally thought to be more transparent than tax-funded models as individuals can see exactly what they are paying for healthcare generally through insurance contributions and what they are receiving through a defined benefits package.[17] *However tax-funded models can also be made more transparent through hypothecated or earmarked taxation such as the income related health levy that currently appears on our pay slips and through defining what services patients are entitled to.*

Choices regarding availability of services must be made in a transparent manner. All parties including patients, doctors and third party payers, must be engaged and represented appropriately in major decisions affecting the delivery of services.

Quality of care and value for money

Quality and value for money must continue to be the core of health service provision in Ireland regardless of whether providers are public, voluntary not-for-profit or private. Standards of care must be based on evidence and international best-practice and must be adequately communicated as well as independently monitored.

The Health Information and Quality Authority (HIQA) is the principal body charged with developing and monitoring quality and safety standards for health services in Ireland and must be adequately funded.

Choice and Mobility

The doctor-patient relationship must be respected. Patients must be allowed to choose their physician.

The doctor-patient relationship is built on trust and understanding and is often built up over time. Contracts between purchasers and providers must not restrict a patient's choice of physician.

Clinical Autonomy

Clinical autonomy must be guaranteed. Physicians must be free to diagnose and treat patients without political interference or interference from third party insurers. Conflicting political and commercial interests must not impact on a doctor's professional duty to act in the best interest of the patient. Doctors must be free to advocate for services on behalf of their patients.

Earmarked taxes and insurance contributions also resolve the issue of political interference as funds cannot be diverted from healthcare to other areas of public expenditure according to political imperatives. Preventing the commercial interests from impacting on clinical autonomy will require strict legislation.

17. Civitas For and Against Social Insurance – The Right Way Forward for Healthcare in the United Kingdom. BMJ 2002. Vol 325. 488-490

Efficiency

The flow of funds, from collection and pooling to purchasing, must be carried out efficiently. In the purchasing or provision of services money must follow the patient.

While the collection and pooling of funds depends on the funding system chosen, the purchasing system is independent. Careful consideration must be given to the payment model. With case-based prospective payment systems, money appears to follow the patient. However they are not necessarily able to capture the multiplicity and complexity of illnesses related to an ageing population, support future delivery models (that is the transfer of many secondary services into a primary care setting) or cope with rapid changes in new technology and treatments.[18]

Affordability

The health care system must be affordable. Measures to contain costs must be evidence-based.

Supply side measures are thought to be more effective than measures that affect demand for services. For example, cost-sharing is known to deter both necessary as well as unnecessary consumption of services and therefore must not be applied to lower socio-economic groups or individuals with higher medical needs. The GP gate-keeper function and health literacy, on the other hand, are considered more effective at reducing overall costs.[19]

Sustainability

The health financing system must be flexible enough to cope with: the needs of an ageing population; future trends in health care provision; increasing public expectations and rapidly changing technology.

While it is possible to predict future trends in population and disease it is much more difficult to predict technological developments and future changes in the delivery of care.[20] *The funding system must allow flexibility to adapt to both foreseen and unforeseen changes in the future and to guarantee stability of funding during economic downturn.*

18. PricewaterhouseCooper's Health Research Institute, You Get What You Pay For – A Global Look at Balancing Demand, Quality, and Efficiency in Healthcare Payment Reform 2008
19. ibid
20. B. Rechel et all 2009. Investing in Hospitals of the Future…p5

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