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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

Table 1
Features of the Irish healthcare system – current and proposed.

Health system characteristic	Current system	Proposed system
Source of financing	Predominantly tax financed, supplemented by private health insurance and out-of-pocket expenditure	Introduction of Universal Health Insurance (purchased by individuals with financial support from taxation revenues for qualifying individuals) to finance some services; general taxation to remain as the core financing mechanism
Number of payers	One large payer (the Health Service Executive (HSE)) and a number of smaller payers in the form of private health insurance companies and private individuals	Multiple competing private insurers for UHI-financed services; the HSE or some other entity for tax-financed services
Separation between purchasers and providers	Limited – HSE main purchaser and provider of healthcare within the public system	Proposed separation between providers and purchasers
Reimbursing providers	Mixed – differs for public and private patients. Lump sum budgets for hospitals, salary for consultants in the public sector, capitation plus fees for GPs in the public sector, fee-for-service for consultants and GPs in the private sector	Money Follows the Patient (MFTP) for UHI financed hospital services
Patient cost-sharing	Medical card holders – limited cost sharing for prescription items Non-medical card holders – full price of GP care (average price €50–€55), prescription items up to €144 a month, €100 a night hospital care up to €750 a year	Unclear; anticipated that GP care will be free at the point of use, however some co-payments will likely remain (for example, for pharmaceuticals)

than systems financed through social insurance [18,19]. There are a number of potential reasons for this including, for example, that social health insurance revenue is earmarked and therefore potentially less subject to political and economic influence than taxation revenue [20]. Alternatively higher expenditure may be related to increased activity within social insurance based systems or could be explained by features or characteristics more generally associated with social insurance, rather than the financing mechanism per se. The following sections identify the features of the Irish healthcare system which would change under the proposed system (Table 1) and discusses the potential impact on healthcare expenditure.

3.1.1. Single versus multi-payer system

At present a single organisation (the Health Service Executive (HSE)) is largely responsible for paying and providing publicly funded healthcare, with private care (within the acute hospital sector at least) largely financed through private health insurance. Under the proposed system of UHI, a multi-payer, competing insurer model will operate with the purchasing of UHI-financed healthcare services largely devolved to insurers (Table 1). It is proposed that the existence of multiple payers may facilitate competition and encourage insurers to reduce their costs and premiums in a bid to attract more customers [7]; however the available evidence does not readily support this assertion [21–23].

There are a number of reasons why a single-payer system may result in lower healthcare expenditure than a system with multiple payers, including lower administrative costs and a greater ability to control healthcare expenditure. A single payer can realise economies of scale in administration [24], while multiple payers mean duplicative claims-processing facilities and smaller insured groups, both of which increase overhead costs [25]. The

use of competing, for-profit insurers within a multi-payer system may further increase expenditure as marketing expenses and profit drive up cost. While the rationale for competition is increased efficiency, the level of competition is often limited so that the anticipated effect is not observed in practice [23,26].

Within a multi-payer system, additional transaction costs may also be imposed on healthcare providers because they interact with a multiple of potential payers. Interactions increase with payers' attempts to manage care, such as requiring prior authorisation for certain services [27]. In addition, each payer will likely have different insurance products, a different list of approved drugs and different rules for billing and submitting claims [27]. Himmelstein et al., for example, found that higher hospital administrative costs in the US and the Netherlands are explained by the use of per patient billing as opposed to lump-sum budgets; as well as a requirement that hospitals bargain over payment rates with multiple payers, whose documentation requirements and billing procedures often vary [28].

Evidence from the Netherlands suggests that attempts to control healthcare costs by encouraging price competition between insurers did not work out as anticipated; while insurers were successful in reducing their operating costs, it was not sufficient to control total expenditure as these costs amounted to only 7 percent of insurers' expenditure [29]. If competing insurers are to drive down costs meaningfully, they must be able to bargain with health service providers. Such selective contracting is relatively rare in the Netherlands [30] and may be even less viable in Ireland due to relative population density [31]. Population density is six times greater in the Netherlands than Ireland and consequently Dutch hospitals tend to be closer together than Irish hospitals. While there are multiple teaching hospitals in Dublin, there are many fewer hospitals in other parts of the country. This could give many

hospitals local monopoly status [31]. Where hospitals are further apart, consumers may be less willing to travel beyond a local hospital. An insurer who contracts selectively may lose market share as enrolees switch to another insurer. Selective contracting could result in geographical barriers in accessing care if insurers do not contract with local hospitals; therefore while concern around equity was one of the reasons for the introduction of the proposed reforms, the model may introduce new equity concerns. Furthermore, price competition between insurers appears to conflict with the principle of equal access based on need rather than ability to pay, which the White Paper states as a key objective of the reform [7].

3.1.2. Separation between purchasers and providers

It is proposed that the role of the HSE as both a purchaser and provider of healthcare be replaced by a purchaser–provider split within the hospital sector for UHI-financed services, with private insurers purchasing healthcare on behalf of their enrolees and hospitals organised into a series of not-for-profit trusts.

Often a purchaser–provider model is introduced with the aim of controlling healthcare expenditure [32]. However, the potential impact of such a model on expenditure is somewhat ambiguous. In the UK an internal market within the health system was introduced in 1991, by separating purchasers from providers and by encouraging competition among providers. Providers became quasi-independent entities managing their own budgets and financing them through contracts with purchasers [32]. The impact of this purchaser–provider split on healthcare expenditure is unclear – one researcher noted that while there was some evidence of an increase in efficiency after the introduction of the quasi-market, administrative costs also increased [33]. In New Zealand, a purchaser–provider split was introduced in 1993 with the aim of achieving greater efficiency and containing overall healthcare expenditure [32]. Despite attempts to estimate the cost of contracting between purchasers and providers, accurate estimates are not available [34]. There is no evidence to suggest that the purchaser–provider split resulted in any major efficiency gains in the hospital sector [35].

3.1.3. Paying providers

Provider reimbursement in Ireland is somewhat unusual in that the method used differs depending on whether the patient being treated is a public or private patient. For GPs an annual capitation payment is made for each patient holding a medical or GP visit card on their list; while they are paid a fee-for-service for each service received by a private patient. Hospitals are largely reimbursed using budget allocations with adjustment for the volume and complexity of activity for the treatment of public patients. Additionally, within the acute public hospital system, the treatment of private patients represents an additional income stream due to the associated charges levied on private patients [3]; in receiving treatment in a private-designated bed in an acute public hospitals, private patients are liable for a maintenance charge in addition to the public hospital inpatient charge. Similarly, consultants

receive a salary for treating public patients and a fee-for-service for the treatment of private patients with the extent of private practice contractually agreed, generally at a maximum of 20 percent.

In the White Paper, a system of MFTP where hospitals are paid for the actual level of activity agreed based on a system of diagnosis related groups is proposed. The move towards MFTP creates incentives to increase the number of patients treated and reduce cost per case [36], but it can have negative consequences including skimming on quality.

In Ireland, there is some evidence to suggest that when MFTP was piloted in a number of orthopaedic sites in Ireland, that volume of activity increased, while length of stay reduced [37]; while in England, where activity-based funding of hospital services was introduced progressively, Farrar and colleague [36] found that length of stay fell more quickly and the proportion of day cases increased more quickly where payment by results was implemented, suggesting a reduction in the unit costs of care associated with payment by results.

Under a system of UHI, it is anticipated that GP visits will be free at the point of use. While the White Paper did not specify how GPs would be remunerated, it has been assumed that GPs will be paid by a combination of capitation and some fee payments [1], as is the case with the recent introduction of free GP visits for those aged under 6 and 70 and over. The potential impact of such a move is twofold including an increase in demand for GP services for those with a reduced price (examined in Section 3.1.4) and a potential change in behaviour by GPs in response to a change in reimbursement, including promoting long-term preventive healthcare or seeking alternative providers of care. However, 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 [38]. Also it may result in ‘cream-skimming’ as providers seek out low-risk patients [39]. However, the cost implications of a change in remuneration will largely depend (at least in the first instance) on the rate at which capitation is set, which will likely be determined through negotiations between government and GP representative groups.

3.1.4. Patient cost-sharing

In the current healthcare system in Ireland, private patients pay the full cost of accessing the GP (Table 1), while also paying out-of-pocket for prescribed medication. Government policy outlined in the Programme for Government noted that “Universal primary care will remove fees for GP care” (6, p. 32). However less clear is how the removal of fees at the point of use will impact on demand for such services, with the magnitude of this effect depending on the price elasticity of demand for GP services. O’Reilly and colleagues found that 26 percent of private patients in Ireland reported having a medical problem but not visiting the GP because of cost, suggesting the existence of an unmet need which may increase demand if user fees are reduced [40]. Nolan found for those gaining free primary care, there was an increase in the annual number of GP visits by between 27 and 39 percent [41].

While the provision of GP care free at the point of use will shift cost from private individuals to the state, the impact on total expenditure is less clear. Assuming that GPs will be reimbursed via capitation, the impact on total expenditure will largely be determined by the rate at which capitation is set. However an increase in GP expenditure could result in a decrease in total healthcare expenditure if it results in a move away from more costly secondary care services, with, for example, Starfield and Shi finding that the better the orientation towards primary care, the lower the total healthcare costs, possibly partly because of better preventive care and lower hospitalisation rates [42].

3.2. Towards an estimate of the potential cost of UHI in Ireland

A number of commentators criticised the White Paper on UHI for its failure to include any estimates of the cost of the proposed model; though a major difficulty in completing such a costing analysis is the lack of detail about how the proposed model would operate in practice, including what basket of services would be financed through UHI. In November 2015, a report was published detailing the potential cost implications of the proposed model [1]. In costing the proposed model of UHI, the analysis adopted assumptions about various aspects of the proposed model including what basket of services would be financed by UHI and the additional costs associated with financing healthcare through multiple, competing insurers.

The analysis estimated that the proposed model of UHI would increase healthcare expenditure in Ireland by between 3.5 and 10.7 percent per annum, translating into a mean per capita UHI cost ranging from €1600 to €2509 [1]. The wide range reflects uncertainties in the proposed model, including the basket of services to be financed by UHI. While some of this additional expenditure was related to the provision of services not provided in the current system, the authors found that a major driver of the increase was the additional cost that arises from financing healthcare through multiple, competing insurers. Initially it was assumed that the UHI system would not be subject to EU competition law. However, the Minister for Health concluded following policy and legal analysis that 'it was not possible to frame a system based on competing insurers in a multi-payer model that would be exempt from competition law' [43], thereby severely limiting the Government's ability to control factors such as pricing and insurers margins [1] and therefore overall healthcare expenditure.

4. Discussion

The available evidence suggests that financing universal healthcare in Ireland via a system of competitive health insurers would lead to an increase in total healthcare expenditure. Although the White Paper model of UHI, as a means of financing universal healthcare, no longer appears to be on the political agenda; there does appear to be a continuing political commitment to universality.

Achieving universal healthcare in Ireland requires an examination of the options to fund universal coverage:

there are no easy paths [44]. Each financing option comes with its own advantages and disadvantages, though the available evidence is suggestive that healthcare expenditure tends to be higher in social insurance financed systems relative to tax-financed [18,19]. Further what works in one country may not necessarily work in another given that the financing system of each country is a product of social and economic considerations specific to the country at the time of the development. In the US, for example, scepticism about government and a strong aversion to taxes has contributed to an aversion to financing universal healthcare coverage through this mechanism [45]. While in the UK, the feasibility of introducing social insurance as a means of financing healthcare was questioned given that the UK may not have the sorts of social institutions manifest in many European countries that made the adoption of social insurance desirable there [46].

Although the White Paper of 2014 has been rejected as a blueprint for reform, given the political and policy consensus about the need to reform the Irish healthcare system, some lessons can be drawn from the experience. Firstly before legislating for, and implementing significant reform, it is necessary to identify and analysis the potential impact of the reforms on a variety of outcomes, including but not limited to cost. Studies such as this could advance the policy discussion without requiring that elected officials make unnecessary early commitments [45]. Doing it earlier rather than later would facilitate the identification and resolution of problems for this and other reform alternatives [45]. Further discussion of healthcare finance reform should be considered alongside more general budgetary issues and challenges including expected demographic and epidemiological changes [45]. Secondly, reform of the nature identified in the White Paper takes time. In Iceland, for example, in moving from social health insurance towards tax-based financing for healthcare, there was a significant transition period (from 1972 to 1989), when sickness funds were retained but received their funding completely from tax payments [32]. While in the Netherlands reform of the health financing system occurred following 20 years of discussion and debate, and ten years after the implementation of legislation is still regarded as reform in progress [47]. Time is needed to explain the proposals and to identify and work out problems for policy, healthcare providers and the public, as well as to alleviate public concerns about significant changes in areas as important as healthcare, health insurance and taxes [45].

5. Conclusions

After a number of years of discussion and the publication of a White Paper, the financing model to achieve universal healthcare in Ireland remains uncertain and contested, in large part due to the expected costs associated with the 2011 Government's proposed model. While Irish political parties have mostly stated a commitment to universal healthcare, advancement on this objective over the next five years will require achieving cross-party support following the February 2016 general election, which returned a minority government dependent on opposition

deputies' agreement to pass legislation. The new Government's programme does not mention UHI; however it does note that further work is required to identify the best way to finance universal healthcare [48]. While the outgoing Government has been criticised for abandoning its model of UHI, it did so based on national and international evidence about the relatively high additional costs associated with this model.

Conflict of interest statement

The authors report no conflict of interest

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