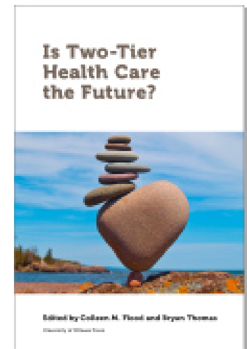
# 11. Embracing and Disentangling from Private Finance: The Irish System

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CHAPTER 11

# Embracing and Disentangling from Private Finance: The Irish System

Stephen Thomas, Sarah Barry, Bridget Johnston,
Rikke Siersbaek, and Sara Burke

The Irish health care system is particularly interesting in that it is one of the few high-income systems that has not achieved significant progress toward universal health care. Indeed, it has only quite recently adopted universality as a formal objective, having been characterized by an entrenched two-tier system for accessing hospitals and market-based general-practitioner access for the majority of the population.[1] Furthermore, the Irish economy battled with the effects of austerity for many years, producing an unhelpful legacy for the Irish health care system in terms of fewer human resources and reduced funding.[2]

In this chapter, we explore the nature and history of the entanglement between public and private financing in the Irish health care system and the impact this has had on system performance. Recent policy proposals to overhaul the Irish health care system, based on the Sláintecare report of 2017, outline a ten-year plan to deliver

1 Sara Ann Burke et al, "From Universal Health Insurance to Universal Healthcare? The Shifting Health Policy Landscape in Ireland Since the Economic Crisis" (2016) 120:3 Health Pol'y 235–240.

2 Sara Burke, "Reform of the Irish Healthcare System: What Reform?" in Mary P Murphy & Fiona Dukelow, eds, *The Irish Welfare State in the Twenty-First Century* (London, UK: Palgrave Macmillan, 2016) at 167 [Burke, "What Reform?"]; Des Williams & Stephen Thomas, "The Impact of Austerity on the Health Workforce and the Achievement of Human Resources for Health Policies in Ireland (2008–2014)" (2017) 15:62 Hum Resour Health.

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universal health care, expand solidarity funding, and remove private finance from public hospitals.[3] Such proposals are explored and evaluated. The challenge of disentangling private and public finance will be a key focus for policy over the next few years.

## Financing the Irish Health Care System

The majority of funding flowing into the Irish health care system comes from general taxation (69 per cent in 2015).[4] This has fallen from a historic high of 76 per cent in 2004 and 2005, at the height of the Celtic Tiger boom, to a low of 68 per cent in 2011–2013, caused by an economic contraction (see fig. 11.1). The other two major sources of funding are out-of-pocket spending (i.e., direct payment to providers when patients access care) and funds flowing through voluntary private health insurers to providers, accounting for 15.4 per cent and 12.7 per cent, respectively, in 2015.[5] The proportion of out-of-pocket payments for health care has remained largely static since 2004, at between 15 per cent and 17 per cent.[6] In contrast, the proportion of financing flowing through private insurers increased sharply over the same period.

Ireland's largely tax-based funding of health care does not bring entitlement to free health care at the point of delivery to the whole population. Unlike most OECD countries, Ireland does not have universal coverage for primary care but instead a safety net system, where those with low incomes are exempted from user fees for key services. The population can be divided into two categories, determined by the 1970 *Health Act*. In category 1 are people with medical cards granted through the General Medical Scheme (GMS), which are primarily allocated on the basis of low income, after a stringent

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3 Ireland, Committee on the Future of Healthcare, *Committee on the Future of Healthcare: Sláintecare Report* (Dublin: Houses of the Oireachtas, 2017), online: <https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf> [Committee on the Future of Healthcare, *Sláintecare Report*].

4 Ireland, Central Statistics Office, *Ireland's System of Health Accounts, Annual Results 2014* (Cork, Ireland: Central Statistics Office, 2016), online: <https://pdf.cso.ie/www/pdf/20180720084024_System_of_Health_Accounts_2014_full.pdf> [Central Statistics Office, *Ireland's System of Health Accounts*].

5 *Ibid*.

6 OECD, *Health at a Glance: Europe 2016* (Paris: OECD Publishing, 2016), online: *OECD iLibrary* <www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2016_9789264265592-en> [OECD, *Health at a Glace: 2016*].

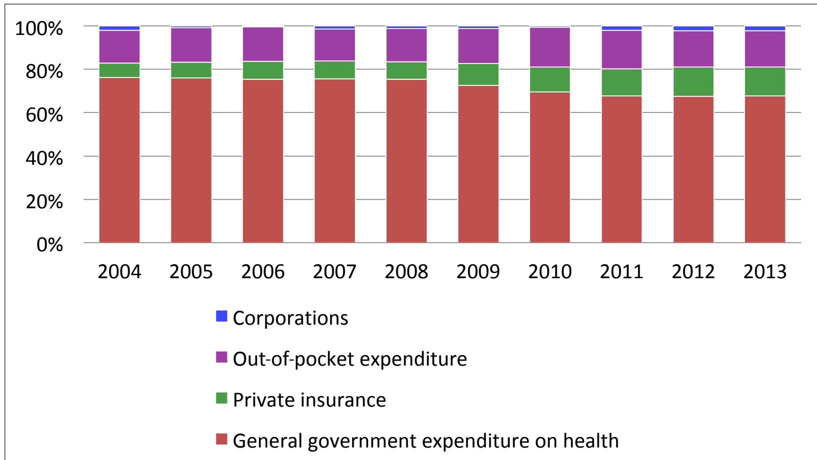


**Figure 11.1 Components of total health expenditure, 2004–2013.**
Source: "Components of Total Health Expenditure" (2004–2013), online: *World Health Organization* <https://www.who.int/>.

means test. A medical card confers eligibility for free access to GP and hospital services, but this is only available to 36 per cent of the population as of April 2017[7] and, as noted, is based primarily on means.[8] GP visit cards, which confer free GP care, are also separately available but only to a much smaller proportion of the population, based partly on means or age (under age sixty and over age seventy).

In category 2 are those without medical cards, estimated at 64 per cent of the population in 2016,[9] who as a consequence must pay full market prices for GP access, alongside user fees at almost every access point of the system and for prescribed drugs. For example, patients pay an average of €52.50 per GP visit and up to €144 per

7 Centre for Health Policy and Management, Trinity College Dublin, "Pathways Indicators" (2017), online: *Trinity College Dublin: The University of Dublin* <www.tcd.ie/medicine/health_policy_management/research/current/health_systems_research/indicators/> [Trinity College, "Pathway Indicators"].

8 Ireland, Health Service Executive, *July 2017 Management Data Report* (Dublin: Health Service Executive, 2017), online:<https://www.hse.ie/eng/services/publications/performancereports/july-2017-management-data-report.pdf> [Health Service Executive, *July 2017 Management Data Report*].

9 Centre for Health Policy and Management, Trinity College Dublin, "Mapping the Pathways to Universal Health Care," online: *Trinity College Dublin: The University of Dublin* <www.tcd.ie/medicine/health_policy_management/research/current/health_systems_research/overview/> [Trinity College, "Mapping Pathways"].

month for prescription drugs.[10] While everyone is eligible for public hospital care, those in category 2 pay €100 per emergency-department visit (without a GP referral) and €80 a day (capped at ten days per year) for hospital treatment (i.e., €800 annually).[11]

## International Comparisons

Ireland spends a significant amount of resources on health care by international standards.[12] This reflects relatively high unit costs for labour and exceptionally high prices for pharmaceuticals.[13] In addition, incentives (such as extra-billing and user charges) and patterns of provision have also tended to promote more expensive modes of delivering care through public hospitals rather than in primary and community settings.[14] This has, in turn, caused significant congestion in hospitals and long waiting lists, spurring yet further private-sector growth. Indeed, a key cause of Ireland's high spending by international standards is also the growth of private health care spending levels, which are now quite high (2.9 per cent of GDP in 2015, the sixth highest of the twenty-eight European Union member states). Indeed, Ireland now has the third-highest proportion of private funding among its EU-15 peers—the fifteen member states before 2004 EU enlargement—exceeded only by Portugal and Greece.[15] Correspondingly, Ireland's share of funding coming from solidarity spending—whether from taxation or compulsory social insurance, where premiums are assessed as a proportion of income—is quite low by EU standards, twentieth among the member states (see the blue bars in fig. 11.2). Across the European Union, the majority of health-system funding is derived from solidarity spending—approximately 79 per cent of total spending in 2014. The remaining portion of expenditure is funded primarily

10 Anne Nolan et al, *The Impact of the Financial Crisis on Health System and Health in Ireland* (London: WHO European Observatory on HealtSystems, 2014), online: <www.euro.who.int/__data/assets/pdf_file/0011/266384/The-impact-of-the-financial-crisis-on-the-health-system-and-health-in-Ireland.pdf?ua=1>.

11 *Ibid.*

12 Trinity College, "Mapping Pathways," *supra* note 9.

13 Nolan et al, *supra* note 10.

14 Committee on the Future of Health Care, *Sláintecare Report*, *supra* note 3.

15 Turner, "The New System of Health Accounts in Ireland: What Does it all Mean?" (2017) 186:3 Ir J Med Sci 533.

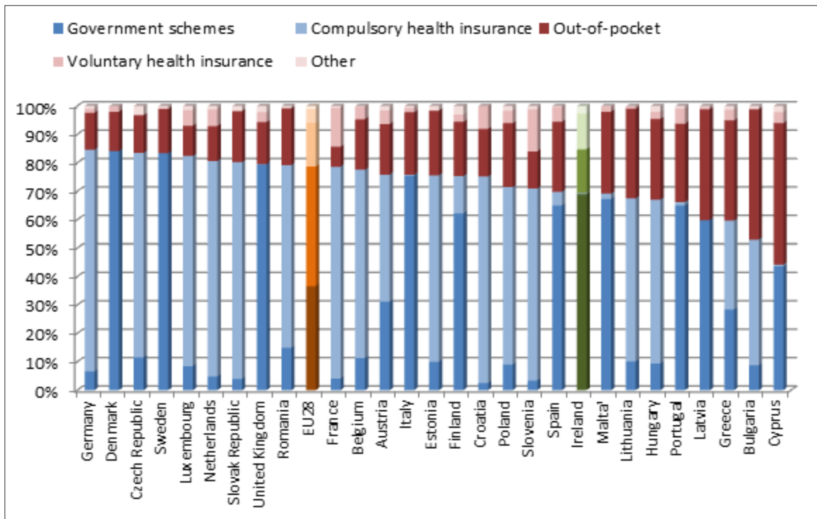


**Figure 11.2. Ireland and solidarity funding of health systems in the EU.**
Source: OECD, *Health at a Glance: Europe 2018* (Paris: OECD, 2012), online: <read.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2018_health_glance_eur-2018-en#page1>.

by household spending on out-of-pocket payments (15 per cent), with private health insurance (PHI) accounting for only 5 per cent.[16]

Current figures suggest that, at 15 per cent, Ireland has the second-highest rate of PHI spending in the European Union as a total proportion of funding, with Slovenia having a marginally higher rate.[17] Moreover, Ireland experienced the greatest growth in PHI as a share of total health spending (7.1 per cent change) across the European Union between 2000 and 2014.[18] This has been a stand-out feature of Irish health financing over the last decade, with PHI as a percentage of total spending increasing 7 per cent in 2004 and 2005, to just under 13 per cent of total funds spent on health in 2015. PHI

16 OECD, *Health at a Glance: 2016*, *supra* note 6.

17 OECD, *Health at a Glance: Europe 2018* (Paris: OECD, 2012), online: <read.oecd-library.org/social-issues-migration-health/health-at-a-glance-europe-2018_health_glance_eur-2018-en#page1>; Central Statistics Office, *Ireland's System of Health Accounts*, *supra* note 4.

18 Anna Sagan & Sarah Thomson, *Voluntary Health Insurance in Europe: Role and Regulation* (Copenhagen: European Observatory on Health Systems and Policies, 2016), online: <www.euro.who.int/__data/assets/pdf_file/0005/310838/Voluntary-health-insurance-Europe-role-regulation.pdf>.

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occupies a unique role in the Irish setting, providing faster access to care in both public and private hospital settings. Perhaps for this reason it expanded its market share during the period of austerity from 2008 to 2014. Nevertheless, it is of note that PHI in Ireland does not cover many out-of-pocket expenditures, as is the case in other European countries with similarly sized supplementary insurance sectors, such as France and Slovenia.[19]

## Private Health Insurance

### *Role*

As argued earlier, PHI occupies a unique role in the Irish setting, providing faster access to care in both public- and private-provider settings. However, it does not always cover hospital expenses, and often covers only a fraction or none of non-hospital care, such as outpatient appointments with a specialist, GP visits, or care from allied health professionals. PHI in Ireland does not cover drugs costs, perhaps because there is already a government-reimbursement threshold for households spending more than a fixed amount in a month. Moreover, the benefits of queue-jumping only accrue to those who are able to afford PHI premiums, and there are concerns about the affordability of PHI. In this section, we explore the historical development of PHI in Ireland, its key features currently, and the main causes of its recent growth and resilience.

### *History*

PHI has been available in Ireland since 1957, where it was solely provided by the state-backed Voluntary Health Insurance Board (under the brand name Vhi Healthcare). It was introduced to take the weight off the public sector for those households that could afford it, with quite small initial uptake. Indeed, more generally, government support for PHI has largely been based on it playing this purported role of removing the burden from the public sector.[20]

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19 Stephen Thomas, Tamás Evetovits & Sarah Thomson, *Analysis of the Health System in Slovenia: Evaluating Health Financing* (Copenhagen: European Observatory on Health Systems and Policies, 2016), online: <http://www.euro.who.int/__data/assets/pdf_file/0005/336398/Evaluating-health-financing-report-Slovenia.pdf?ua=1>.

20 Francesca Colombo & Nicole Tapay, *Private Health Insurance in Ireland: A Case Study* (Paris: OECD, 2004).

This state-backed monopoly on PHI was effectively ended after EU intervention in the mid-1990s opened up the insurance market for competition. As a consequence of this liberalization, over the last twenty years there have been a number of private insurers that have entered and exited the Irish market. The dominant role of Vhi, the original state-backed PHI, has slowly eroded over this time as other PHI firms joined the market, mainly competing for younger and healthier membership. Vhi has by far the worst risk profile of all the private insurers, although it continues to have around 50 per cent of the PHI market.[21]

The Irish government has attempted to ameliorate problems with PHI through regulation. As a consequence, since 1994, the market has been quite heavily regulated, operating under the principles of intergenerational solidarity, with single-rate community-rating regulations, whereby insurers are required to charge all individuals the same premium per plan (subject to some exemptions). The market is also subject to open enrollment, lifetime cover, and minimum benefit regulations.[22] Market segmentation and diversification of products, though, has nonetheless enabled insurers to cream skim the young and healthy.

Further, the PHI market operated for a long time without a risk-equalization scheme, and when the government attempted to introduce such a scheme in 2005, it was declared unconstitutional by the courts and a fully developed risk-equalization scheme was only introduced in 2013. This replaced a basic system of additional age-related tax credits introduced in 2009.[23] Consequently, for many years little was done to disincentivize risk selection, meaning that a key profit focus for private health insurers was attracting low-risk members rather than seeking to reduce the costs of care. In turn, this contributed to market segmentation, which in turn undermined community-rating regulations.[24] Furthermore, while no risk-equalization

21 "Market Figures" (March 2015), online (PDF): *The Health Insurance Authority* <www.hia.ie/sites/default/files/HIA_Mar_Newsletter_2015.pdf>.

22 Conor Kegan et al, "Switching Insurer in the Irish Voluntary Health Insurance Market: Determinants, Incentives, and Risk Equalization" (2016) 17:7 Eur J Health Econ 823.

23 *Ibid*.

24 Brian Turner & Edward Shinnick, "Community Rating in the Absence of Risk Equalisation: Lessons From the Irish Private Health Insurance Market" (2013) 8:2 Health Econ Pol'y L 209.

scheme can entirely remove incentives for risk selection, there are recognized weaknesses in the existing scheme, which could be improved upon to further reduce incentives to cream skim.[25]

Given the increasing popularity of PHI, the Fine Gael–Labour coalition government of 2011 proposed it to be the basis of a universal health insurance, modelled on the Dutch managed-competition system.[26] *The Path to Universal Healthcare*—the white paper on universal health insurance, the legislative basis for the introduction of universal health insurance—was published by the government in April 2014.[27] It proposed an eventual "multi-payer" model of compulsory PHI for all citizens, with for-profit insurance companies operating in competition as per the Dutch approach, but its implementation was delayed until 2019. Despite the plan to universalize PHI and transform it through regulation into the basis of the public plan, a substantial portion of funds was still to come from taxation and to be funnelled through the insurers.[28] In November 2015, long-awaited costings of the proposed model were published, which found that it would require annually between €666 million and €2 billion more than current health spending.[29] The then health minister concluded that this particular model was "not affordable now nor ever."[30] Previous research has predicted that this would be the case, given the experience in the Netherlands.[31]

25 Conor Keegan et al, "Switching Benefits and Costs in the Irish Health Insurance Market: An Analysis of Consumer Surveys" (2019) 19:1 Int J Health Econ Manag 15.

26 Sara Ann Burke et al, "From Universal Health Insurance to Universal Healthcare? The Shifting Health Policy Landscape in Ireland Since the Economic Crisis" (2016) 120:3 Health Pol'y 235.

27 Ireland, Department of Health, *The Path To Universal Healthcare: White Paper on Universal Health Insurance* (Dublin: Department of Health, 2014), online: <health.gov.ie/wp-content/uploads/2014/04/White-Paper-Final-version-1-April-2014.pdf>.

28 *Ibid.*

29 Maev-Ann Wren, Sheelah Connolly & Nathan Cunningham, *An Examination of the Potential Costs of Universal Health Insurance in Ireland* (Dublin: Economic Research Institute, 2015), online: <www.esri.ie/pubs/RS45.pdf >.

30 Ireland, Department of Health, *Statement by Minister Varadkar following Cabinet discussion on UHI* (Dublin: Department of Health, 2015), online: <health.gov.ie/blog/press-release/statement-by-minister-varadkar following-cabinet-discussion-on-uhi/>.

31 P Ryan, S Thomas & C Normand, "Translating Dutch: Challenges and Opportunities in Reforming Health Financing in Ireland" (2009) 178:3 Ir J Med Sci 245.

With the withdrawal of this policy commitment to making PHI the basis of the universal plan, and because of concern about the role and viability of PHI, the outgoing minister for health proposed a policy of lifetime community rating. The aim of this was to bring more young people into the PHI market after the austerity reduction in enrollment to stabilize the market and consolidate the industry. The policy penalized those enrolling for PHI for the first time at age thirty-five and over by imposing late-entry loadings, up to a maximum loading of 70 per cent, subject to some exemptions.[32]

### *Demand for PHI*

The main benefits of PHI in Ireland relate to its role of providing faster access to elective (i.e., non-emergency) hospital care for its beneficiaries. However, it also covers charges for acute care (whether in private or public hospitals). For non-acute services, such as GP and physiotherapist services, PHI cover tends at best to reimburse only part of the cost. Critically, depending on the type of insurance, PHI may not cover part or all of the cost of an outpatient appointment with a specialist.

Recent consumer surveys from the Health Insurance Authority note that key reasons for consumers voluntarily purchasing PHI are perceived poor quality of public care, high cost of private care, and limited access to public care.[33] The last point has been of increasing concern over the past ten years as wait times and lists in Ireland, already poor by international standards, have increased significantly for both inpatient and outpatient treatment, even after the austerity period (see figs. 11.3 and 11.4).

Despite apparent concerns about public care, a key aspect of some PHI funded provision is that it takes place in public hospitals, thus "crowding out" access for public patients in the sense that it takes away potential treatment spots for public-pay patients.[34] Concerns have been raised that individuals with PHI are, in effect, having their access cross-subsidized from the public purse through

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32 Conor Keegan et al, "Addressing Market Segmentation and Incentives for Risk Selection: How Well Does Risk Equalisation in the Irish Private Health Insurance Market Work?" (2017) 48:1 Econ Soc Rev 61.

33 *Ibid*.

34 BM Johnston et al, "Private Health Expenditure in Ireland: Assessing the Affordability and Sustainability of Private Financing of Health Care" (2019) 123:10 Health Pol'y 963.

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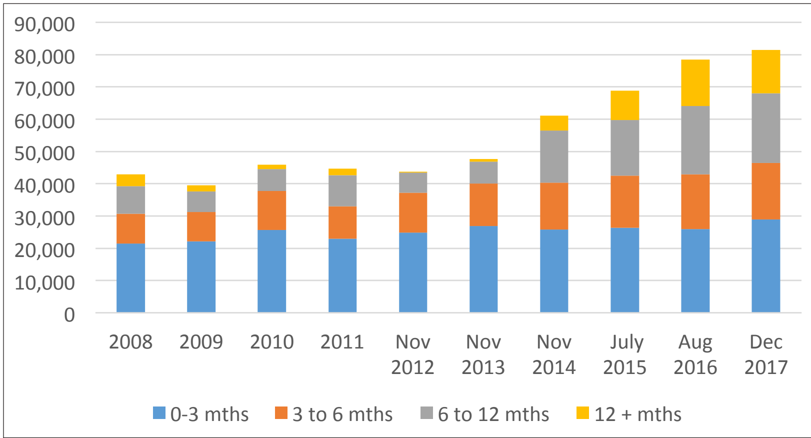


**Figure 11.3. Number of adults waiting for inpatient hospital treatment, 2008–2017.**
Source: Centre for Health Policy and Management, Trinity College Dublin, "Pathways Indicators" (2017), online: *Trinity College Dublin: The University of Dublin* <www.tcd.ie/medicine/health_policy_management/research/current/health_systems_research/indicators/>.

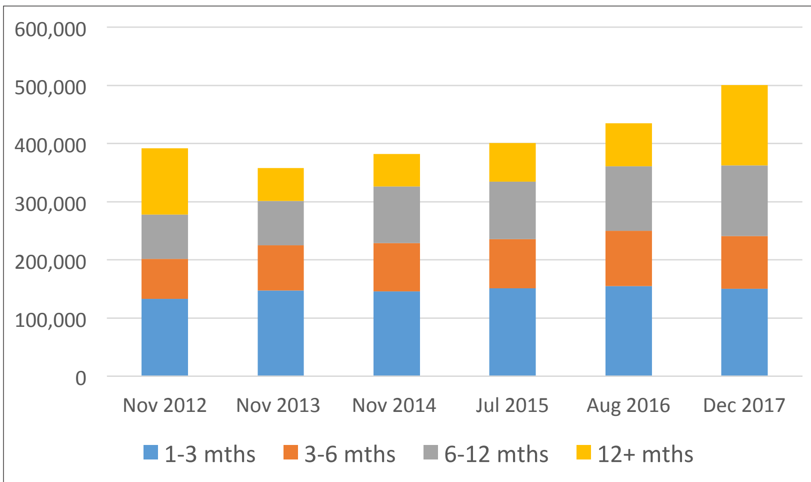


**Figure 11.4. Number of adults awaiting outpatient appointments, 2012–2017.**
Source: Centre for Health Policy and Management, Trinity College Dublin, "Pathways Indicators" (2017), online: *Trinity College Dublin: The University of Dublin* <www.tcd.ie/medicine/health_policy_management/research/current/health_systems_research/indicators/>.

tax breaks and relatively low prices charged by public hospitals to PHI patients. In recent years, however, there has been some unwinding of tax subsidies for those with PHI, and charges for private care in public hospitals have increased substantially to better reflect the full cost of care.

The waits, discussed above, for an initial appointment with a specialist (in the form of an outpatient appointment) and for treatment do not capture waits that happen before these stages. Research carried out with GPs found:

- In the public system 70–80 per cent of GPs have no direct access to CT scans. Even where it is available, there is an average sixteen-week wait. In the private system, 90 per cent of GPs have access to CT scanning, with an average waiting time of 5.5 working days. Furthermore, the average wait for MRI scans in the public system was twenty-two weeks, varying from six days to seventy-two weeks. Virtually all GPs have direct access to an MRI scan in the private sector within seven working days.
- The majority (86 per cent) of GP respondents were of the opinion that increased access to diagnostics would reduce their referrals to emergency departments and improve the quality of their referrals. When questioned regarding outpatient-department referrals, 90 per cent felt that improved access would reduce such referrals, while 92 per cent felt this would improve the quality of these referrals. Overall, 87 per cent believed that improved access to diagnostics would reduce unnecessary admissions.[35]

While this research is over five years old, there is no reason to believe access to diagnostics has improved in the public system, and improving access to diagnostics is a key recommendation in the Sláintecare report.[36] People who privately get these diagnostics tests outlined above either pay wholly or partly out of pocket, or they may be covered by their PHI.

35 Margaret O'Riordan, Claire Collins & Gillian Doran, *Access to Diagnostics: A Key Enabler for a Primary Care Led Health Service* (Dublin: Irish College of General Practitioners, 2013).

36 Committee on the Future of Healthcare, *Sláintecare Report*, *supra* note 3.

### *Coverage*

Over the austerity period, PHI coverage dropped from a high of 52 per cent of the population in 2007 to just under 44 per cent at the end of 2014. By September 2016, the numbers holding PHI had increased slightly, to 44.8 per cent, likely because of the introduction of the lifetime community-rating policy and general economic recovery.[37]

## Recent Austerity Context

Ireland experienced a deep and long economic crisis between 2008 and 2014 that led to six austerity budgets. In Europe, the severity of the recession experienced by the Irish economy was only bettered by the Baltic States in the initial years after the 2008 global market crash.[38] However, the duration of the economic slump in Ireland was much worse, and only Greece experienced a longer economic crisis among the EU-15 countries. Ireland was only one of a handful of countries bailed out by the troika of the European Union, the European Central Bank (ECB), and the International Monetary Fund (IMF). Key statistics are that gross national income contracted sharply, by 9 per cent in 2009; unemployment grew quickly, from a low of 4.6 per cent to 14.7 per cent from 2007 to 2012; the country's debt-to-GDP ratio increased from 25 per cent to 124 per cent from 2006 to 2014; and a massive gap in public-sector financing of €2.7bn (a deficit of 17 per cent) opened up by 2014.[39]

The deep and prolonged economic crisis in Ireland had the effect of increasing the importance of private health funding and, in particular, PHI to overall health-system funding patterns. Austerity measures were introduced between 2008 and 2013, and their impact is still being felt, even after the economy recovered and returned to high levels of economic growth.[40]

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37 Sara Burke et al, "Indicators of Health System Coverage and Activity in Ireland During the Economic Crisis 2008–2014—From 'More With Less' to 'Less With Less'" (2014) 117:3 Health Pol'y 275.

38 Conor Keegan et al, "Measuring Recession Severity and its Impact on Healthcare Expenditure" (2013) 13 Intl J Health Care Fin & Econ 139.

39 Stephen Thomas et al, "A Framework for Assessing Health System Resilience in an Economic Crisis: Ireland as a Test Case" (2013) 13:450 BMC Health Serv Res.

40 Johnston et al, *supra* note 34.

Out-of-pocket payments increased over the austerity period. This increased the financial burden on households as each person had to pay, on average, an additional €120 per person per year to access the same health services.[41] Furthermore, unmet need increased sharply between 2010 and 2014, pushing Ireland above the EU average, suggesting an increased number of people were unable to afford or access care in relation to both general medical and dental examinations.[42]

During the economic downturn, successive budgets sought to shift a greater proportion of the costs of funding health care onto households. Recent research shows that nearly €600 million of the cost of some aspects of health care was transferred from the state onto people between 2008 and 2014.[43] Policies included the introduction of prescription charges for medical card holders, increased emergency-department charges, increased thresholds for reimbursement under the country's Drug Payment Scheme, and reduced medical card eligibility.

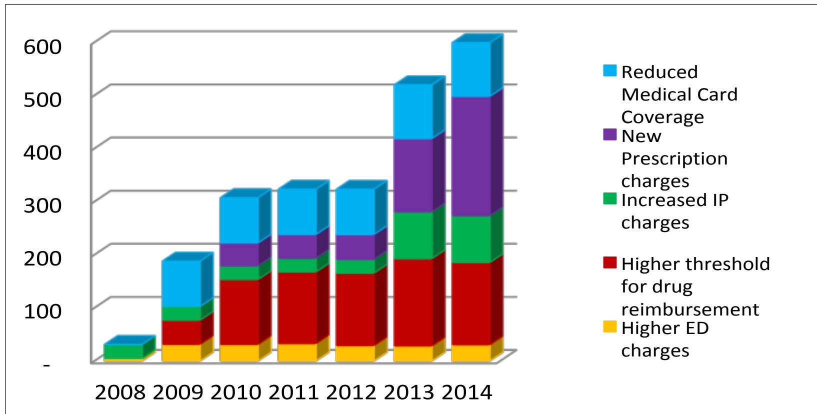


**Figure 11.5. Cost shifting from the state to households, 2008–2014.**
Source: Centre for Health Policy and Management, Trinity College Dublin, "Pathways Indicators" (2017), online: *Trinity College Dublin: The University of Dublin* <www.tcd.ie/medicine/health_policy_management/research/current/health_systems_research/indicators/>.

41 OECD, *Health at a Glance: Europe 2012* (Paris: OECD, 2012), online: <www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2012_9789264183896-en> [OECD, *Health at a Glance: 2012*].

42 *Ibid*; OECD, *Health at a Glance: 2016*, *supra* note 6.

43 Stephen Thomas, Sara Burke & Sarah Barry, "The Irish Health Care System and Austerity: Sharing the Pain" (2014) 383:9928 Lancet 1545.

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Ireland was not alone in expanding the role for private finance as a response to the financial crisis—many countries in Europe introduced measures aimed at expanding private finance.[44] These policies are often portrayed as effective mechanisms for improving the efficiency of health systems. However, such arguments may also be a convenient rationale for reducing state spending. They also come to the fore when public-sector budgets are highly constrained. This was exacerbated by the financial bailouts of countries across Europe by the EU/ECB/IMF troika, and their imposed spending constraints. Interestingly, early cutbacks in Ireland may well have had some efficiency dividends in the public sector, but later cuts just reduced service provision and access.[45]

At the same time that many governments in Europe pushed costs on to households, households themselves faced difficult choices over health care payments as a result of reduced disposable income. In Ireland, data from household-spending surveys shows that households prioritized health insurance coverage over out-of-pocket payments.[46] This trend presents three challenges:

- Insurance-premium payments are absorbing and increasing proportion of household disposable income, which means citizens do not have the financial resources needed to access GPs and dentists, which are critical primary-care services.
- As individuals delay seeking the primary care they need because of cost, this may exacerbate current bottlenecks in, for example, hospital emergency departments.
- Paying PHI premiums is presenting a problem of affordability and financial protection, particularly for those with the lowest economic means. Interestingly, there is evidence that significant numbers of the poorest 40 per cent of the population, who are frequently eligible for a medical card

44 Marina Karanikolos et al, "Financial Crisis, Austerity, and Health in Europe" (2013) 381:9874 Lancet 1323; Gianluca Quaglio et al, "Austerity and Health in Europe" (2013) 113:1 Health Pol'y 13; Oliver J Wouters & Martin McKee, "Private Financing of Health Care in Times of Economic Crisis: a Review of the Evidence" (2017) 8:23 Glob Pol'y 2.

45 Burke et al, *supra* note 37.

46 Johnston et al, *supra* note 34.

> and free care, are taking out PHI, which is causing them financial hardship.

As the Irish government was shifting costs onto households, it was simultaneously reducing its funding of the health care system and, as a consequence, reduced human-resource levels by around 7 per cent.[47] There were 8,027 fewer whole-time equivalent directly employed in the Health Service Executive, the main public sector health care employer, in 2014 than there was in 2008. There was a degree of relative protection for frontline staffing, which only decreased by 2.9 per cent between 2008 and 2014, but, counter to stated policy, the decline in staffing of non-acute care was over double the decline in acute care. Further, the reduction in directly employed staff was largely matched by a marked increase in hospital spending on temporary staff recruited through agencies.

When the economy and the health budget returned to growth in 2015, the recovery in health human resources was again biased away from cost-effective non-acute services, perpetuating the Irish system's over-dependence on hospitals.[48] Figure 11.7 contrasts the human-resource (HR) trends in acute and community services. By December 2016, the levels of acute HR were back to pre-crisis levels, compared to the HR levels for community and primary-care services, which continued to fall far short of needs. Again, such imbalances have tended to exacerbate capacity and cost problems in the Irish health care system.

Staffing levels have continued to grow; by December 2017, there were 110,795 staff in the public health system, akin to pre-crisis staff levels.[49] Nevertheless, the gap between staffing of acute and non-acute services has not been addressed. This will create further pressure on the hospital sector, as it is used for care which should be provided in other parts of the system.

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47 Des Williams & Stephen Thomas, "The Impact of Austerity on the Health Workforce and the Achievement of Human Resources for Health Policies in Ireland (2008–2014)" (2017) 15:62 Hum Resour Health.

48 Health Service Executive, *July 2017 Management Data Report*, *supra* note 8.

49 Ireland, Department of Public Expenditure and Reform, *Mid-Year Expenditure Report 2018* (Dublin: Department of Public Expenditure and Reform, 2018), online: <www.per.gov.ie/wp-content/uploads/MYER-2018_-web-version.pdf>.

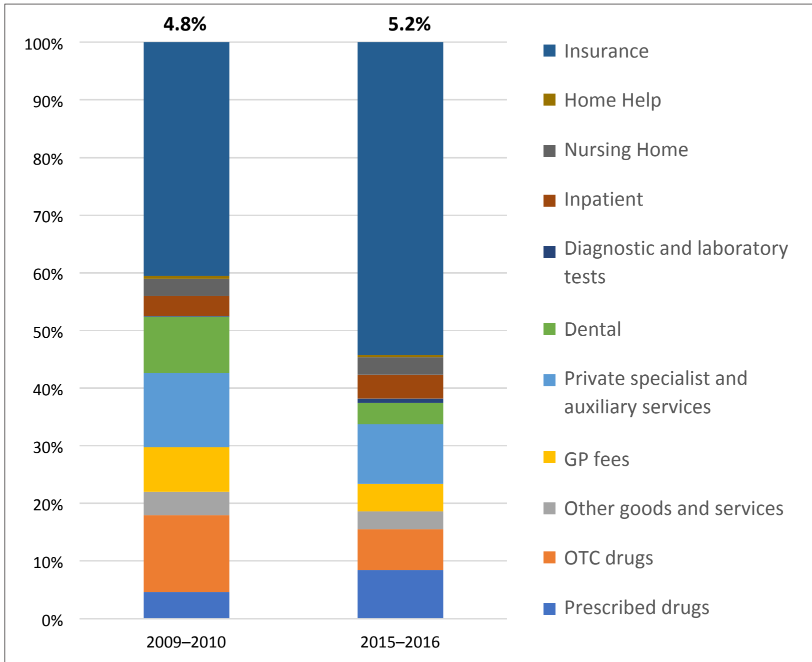


**Figure 11.6. Proportion of household private spending on health care by type.**

Source: Central Statistics Office, Ireland (2019), online: https://www.cso.ie/en/index.html.

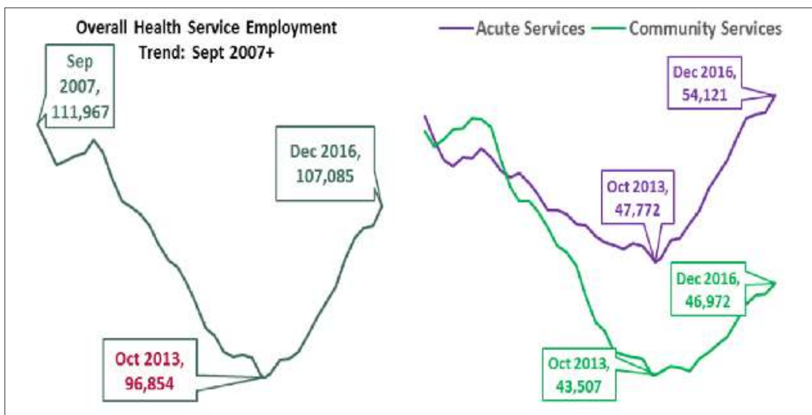


**Figure 11.7. Health service employment trends, 2007–2016.**

Source: Centre for Health Policy and Management, Trinity College Dublin, "Pathways Indicators" (2017), online: *Trinity College Dublin: The University of Dublin* <www.tcd.ie/medicine/health_policy_management/research/current/health_systems_research/indicators/>.

## Policy Response and Sláintecare

The general election in March 2016 delivered a minority government as voters proved tired of both established parties and austerity policies. The largest party, Fine Gael, with 25 per cent of the vote, was not able to form a stable government coalition despite arrangements with some smaller parties and independents. Instead, a Fine Gael minority government was propped up through a supply-and-confidence arrangement with the main opposition party, Fianna Fáil, and the support of a range of independent members of parliament.[50] As a result, legislation could only be passed through consensus across government and substantial parts of the opposition. This consensus work was dubbed the era of "new politics," and the health care reforms perhaps owe much to this era of joint work and compromise.[51]

In early May 2016, Deputy Roísín Shortall, a former junior health minister and co-leader of a small centre-left party, the Social Democrats, launched an all-party motion on health signed by eighty-nine Teachtai Dála (or TDs, members of Dáil Éireann, the lower chamber of parliament) out of a total of 158. The motion was to establish an all-party committee with a remit of agreeing on a ten-year strategy for health reform, including the delivery of a single-tier universal health service, and switching emphasis to primary and social care.

The day after the motion was introduced, the newly formed government published its Programme for Partnership Government, which included a commitment to "request an Oireachtas All-Party committee to develop a single long-term vision plan for healthcare over a 10 year period. This plan should have cross party consensus."[52]

In the face of continued intractable problems of long waiting lists, massive overcrowding in emergency departments, profound inequities, a backlog of underinvestment, and the absence of his own party's health policy, a new minister for health, Simon Harris, proposed

50 Sara Burke, "Achieving a Plan for Universal Healthcare in Ireland Through Political Consensus Post Austerity" (2018) 122:12 Health Pol'y 1278 [Burke, "Achieving a Plan"].

51 *Ibid.*

52 Ireland, Department of the Taoiseach, *A Programme for a Partnership Government* (Dublin: Department of the Taioseach, 2016) at 63, online: <https://assets.gov.ie/3221/231118100655-5c803e6351b84155a21ca9fe4e64ce5a.pdf>.

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> an Oireachtas [Irish legislature] all-party committee to develop a single long term vision plan for healthcare over a 10 year period … [and concluding that] key to the long-term sustainability of our health service and Universal Healthcare … is the development of a new funding model for the health service.[53]

This is considered the first act of the new politics, as the government here adopted an opposition motion.[54]

The Oireachtas Committee on the Future of Healthcare was established in June 2016 and met between July 2016 and May 2017. It was composed of fourteen TDs across the political spectrum, as specified in the Dáil motion, including Deputy Shortall, who was elected its chairperson. The committee held thirty public hearings, received 167 submissions from the public and interested bodies, and published two interim reports. In November 2016, the committee engaged a team (the authors of this chapter) from the Centre for Health Policy and Management, in Trinity College Dublin. The Trinity team worked with the Oireachtas committee in hosting the first-ever expert-led workshops in the history of the Irish Parliament, where useful health systems frameworks and international evidence were presented.[55] The resulting report, Sláintecare, has proved highly influential, not least because it represented a "unique and historic opportunity for TDs from across the political spectrum to come together to develop consensus on a long-term policy direction for Ireland's healthcare system."[56]

The core aims of Sláintecare are to establish:

- a universal, single-tier health service, where patients are treated solely on the basis of health need;
- a reorientation of the health system "towards integrated primary and community care, consistent with the highest quality of patient safety in as short a time-frame as possible."[57]

The report outlines a ten-year plan for transformation of the Irish health system on the basis of key policy recommendations, including:

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53 Department of the Taoiseach, *supra* note 52.

54 Burke, "Achieving a Plan," *supra* note 50.

55 Committee on the Future of Healthcare, *Sláintecare Report*, *supra* note 3; Burke, "Achieving a Plan," *supra* note 50.

56 Burke, "Achieving a Plan," *supra* note 50.

57 Committee on the Future of Healthcare, *Sláintecare Report*, *supra* note 3.

- Introduction of entitlements to care (rather than just eligibility for care).
- Introduction of free care for hospital admissions and GPs, reduction of copayments for medicines, and expansion of public funding.
- Expansion of the primary-care workforce and reorientation toward the primary-care system.
- Removal of private insurance funding from public hospitals (over six years).
- Wait time guarantees, backed up by increased accountability and information.
- A transitional fund to support capacity expansion in the system, and to address the capital backlog acquired over the austerity years.

The report adopts a World Health Organization definition of universal health care and specifies a comprehensive basket of services to be included in a universal health system. In relation to PHI, the report makes the following commitments:

> The Committee also proposes the phased elimination of private care from public hospitals, leading to an expansion of the public system's ability to provide public care. Holders of private health insurance will still be able to purchase care from private healthcare providers.
>
> …
>
> It recommends a model where private insurance will no longer confer faster access to heal thcare in the public sector but is limited to covering private care in private hospitals.
>
> …
>
> Reliance on private health insurance may also fall as access to our public healthcare system improves. It is estimated that as the expanded entitlements are phased in, household direct expenditure overall will fall by around €148m each year on average, through reductions in out-of-pocket costs and some reduced private health insurance costs.[58]

58 *Ibid* at 17, 25, 132.

The report estimates the costs of the removal of private care from public hospitals to be €649 million per year, and this removal is phased from years two to six of the plan. The committee also "proposed an independent impact analysis of the separation of private practice from the public system with a view to identifying any adverse and unintended consequences that may arise for the public system in the separation."[59] An independent group was established by the government in 2017 to conduct this analysis and submitted its final report in February 2019.

## Implications for Private Funding of the Irish Health Care System

There will be substantial implications for the funding of health care in the Irish system if Sláintecare proposals are fully implemented. First, by establishing free care for GPs and hospital inpatient and emergency-department access, and by reducing drug-reimbursement thresholds and lowering prescription charges, out-of-pocket payments will be reduced from 15.4 per cent to 8.5 per cent (fig. 11.8). Instead of patients paying user charges to access care, more funding

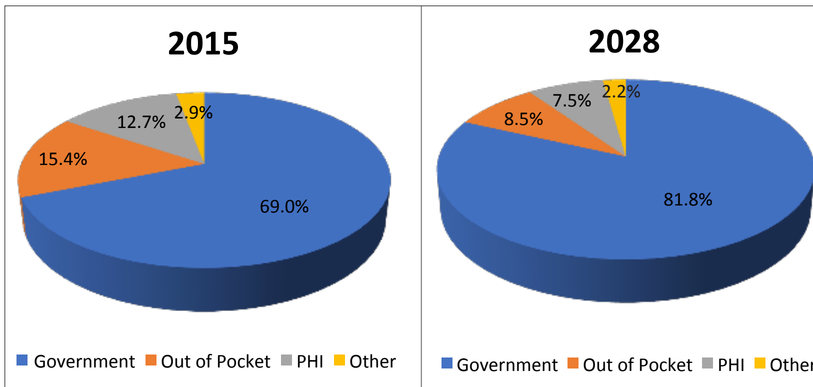


**Figure 11.8. Change in shares of health financing as a result of Sláintecare 2015 and 2028.**

Source: Central Statistics Office, Ireland, (2019), online: <https://www.cso.ie/en/index.html>; Centre for Health Policy and Management, Trinity College Dublin, "Pathways Indicators" (2017) https://www.tcd.ie/medicine/health_policy_management/research/current/health_systems_research//.

59 Committee on the Future of Healthcare, *Sláintecare Report*, *supra* note 3.

will come from taxation or other public sources. Extra taxation will also fund the gap in public hospital funding caused by the removal of PHI as a funding source. The resultant increase in taxation-based funding will expand its share to almost 82 per cent of aggregate health care funding. In relation to international funding patterns shown in figure 11.2, this would bring Ireland substantially above the EU average, and positioned ahead of the Netherlands, the Slovak Republic, and the United Kingdom. Since PHI would no longer fund faster access to the public hospital system, demand for it would reduce. In this case, it is estimated that the share of PHI of overall funding would fall from 12.7 per cent to 7.5 per cent from 2015 to 2028, which is much closer to the EU average.

It is interesting to note that Sláintecare does not mark the abolition of private financing in the Irish health care system, but it does signify an important shift from allocating access to care on one's ability to pay to medical need. Those with PHI will still be able to access care in public hospitals, but they will not get faster access to that care. They will still be able to seek private care in private hospitals according to the coverage offered by their insurer.

## Key Challenges Ahead

For Sláintecare to be successful, careful attention must be given to disentangling the public and private sectors. Key challenges are summarized below.

### *Changing Financial Incentives*

*Fee for service for doctors for private activity in public hospitals to be removed.* Currently, many consultants have contracts that allow them to work in the private sector over and above their public-sector activity, given a minimum time commitment in their public hospital work. Nevertheless, recent investigative journalism has uncovered that there is a substantial minority of consultants who do not meet their minimum time commitments in public-sector activity.[60] While this may be less important where waiting lists and times are short

60 "RTÉ Investigates—Public v Private; The Battle for Care," *RTÉ News* (1 February 2018), online: <www.rte.ie/news/investigations-unit/2017/1122/922105-rte-investigates-public-v-private-the-battle-for-care/>.

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for public acute procedures, it is apparent that some consultants both have long waiting lists and also fail to honour their public-sector contracts in relation to minimum hours worked. At face value, removing private funds from public hospitals may impact consultant incomes, though consultants would still be able to practice in private hospitals. Nevertheless, there is concern that there would need to be a change of consultant contracts, and given the history of such negotiations, this may prove to be a difficult and long-winded affair.

*PHI insurance payment to public hospitals to be removed.* As noted, PHI in some instances covers patients to be treated faster in private beds in public hospitals. With this removed, a small but key source of funding would be taken away from public hospitals at a time when budgets are stretched. Nevertheless, the PHI funding of public hospitals is quite a small proportion of overall acute funding, and its significance has been dropping in recent years. Also, Sláintecare includes an estimate of public compensation of this funding source to be phased in over several years, allowing more patients to be seen publicly (as detailed above).

#### *Resolving Access Problems*

*Reduce wait times.* In order to break the cycle of demand for PHI, the public system must significantly address access problems for public patients. In large part this means addressing the terrible waiting times that patients face for public treatment. Many other countries have achieved great gains in this area over the past decade, primarily through wait time guarantees, enhanced accountability, public engagement with wait time data, and strategic purchasing of care for those experiencing long wait times.

*Reduce burden on hospitals*. Currently, there is insufficient capacity outside hospitals in primary-, community-, and social-care settings. This tends to suck patients unnecessarily into hospitals, into crowded emergency departments, and into longer hospital stays than necessary. Furthermore, high GP fees do little to encourage earlier access as to time-sensitive health care problems. There is some evidence that crowded emergency departments translate into higher emergency-related admissions, which in turn are crowding out elective care and causing longer wait times. Sláintecare outlines a plan for substantial

investment in primary- and community-care staffing and infrastructure, alongside fee removal, toward redefining the appropriate role of hospitals and reducing the demand and perceived need for private financing mechanisms.

### *Shifting Public Perceptions*

Perhaps the most challenging aspect of Sláintecare is to change the pervading public narrative that the public system cannot be trusted to provide quality and timely care. In a recent survey, only 22 per cent of the population thought public care was good enough, and 58 per cent thought PHI was a necessity.[61] The issue of lack of trust in the public sector has, in recent times, been further eroded by periodic scandals around non-disclosure of vital information[62] and poor quality of services.[63] It is further made difficult by powerful interest groups, for example, the Irish Hospital Consultants Association, which has publicly disparaged potential reforms in favour of the status quo, which is to its advantage.[64]

## Conclusion

The introduction of PHI in Ireland allowed a two-tier system to develop, with long wait lists in the public system and limited financial protection. The government is now looking at a radical reform program to reorient the system, establish universal health care, and remove private insurance financing from public hospitals. The disentangling of the public and private systems is not an easy task; it will take careful planning, sequencing, coalition building, and

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61 Kantar Millward Brown, *A Review of Private Health Insurance in Ireland, 2017* (Health Insurance Authority, 2017), online: <www.hia.ie/sites/default/files/Consumer%20Survey%20on%20the%20private%20health%20insurance%20market%20in%20Ireland%202017.pdf>.

62 Fergal Bowers, “What is the Cervical Check Controversy About?,” *RTÉ News* (12 September 2018), online: <www.rte.ie/news/analysis-and-comment/2018/0427/958788-cervical-cancer-q-a/>.

63 Ellish O’Regan, Katherine Donnelly & Ryan Nugent, “Damning Report Highlights Litany of Failures at Maternity Hospital,” *Irish Independent* (17 June 2019), online: <www.independent.ie/ca/irish-news/health/damning-report-highlights-litany-of-failures-at-maternity-hospital-36872141.html>.

64 Martin Wall, “State Must Contemplate Perceived Flaws in Sláintecare Policy,” *The Irish Times* (7 August 2018), online: <www.irishtimes.com/news/health/state-must-contemplate-perceived-flaws-in-sl%C3%A1intecare-policy-1.3587993>.

changing the public narrative about the nature of the health system. Nevertheless, these are worthwhile challenges to take on in order to deliver a truly universal health care system for Ireland.

While Canada might be considering an expanded role for private health insurance, such a decision needs to be taken with sober judgement. It cannot be easily unwound. PHI was initially introduced in Ireland to take some pressure off the government. However, its introduction has impeded a fair, efficient, and integrated system, and there has been substantial profiteering by smaller insurers since liberalization. It has taken sixty years to develop a plan that will disentangle public and private financing. Implementation will take another ten years at least. It must be questioned as to whether Canada can afford such a lengthy and difficult journey.