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Healthcare Systems:  
Ireland & 'Universal  
Health Insurance' –  
an emerging model  
for the UK?

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## Introduction

Healthcare in the Republic of Ireland currently centres on a centrally-administered national health service financed mostly from general taxation, now known as the Health Service Executive (HSE). In this sense, Irish healthcare has historically had similarities with the British NHS, although it should be noted that in its existing form the HSE model is marked by a slightly larger reliance on mixed provision and funding. Like Britain, however, the Irish have historically encountered issues with waiting times, funding, centralisation, accountability, technological uptake and clinical outcomes in the HSE, at least when compared to some other universal healthcare nations on the continent. Ireland also has a complex multi-tier system of healthcare, in which people on lower or middle incomes sometimes struggle to access needed care while people with private voluntary health insurance get preferential access to care in state hospitals or to higher-quality treatment in the separate private hospital sector, similar to the privileged position the wealthy or insurance-holders have in the UK's healthcare landscape. These problems have led to a feeling in the Irish population that their current healthcare system guarantees neither quality nor genuine equity.

Following a 2011 change of government to a coalition between the centre-right Fine Gael and the centre-left Labour Party, the Irish system is now in the midst of a radical and ambitious overhaul known as Universal Health Insurance (UHI), based on an amalgamation of plans put forward by both parties before the 2011 Irish election. UHI is essentially a plan to convert Ireland's several-tier, centralised tax-financed system into a continental-style 'Bismarckian' social health insurance system with a main tier of universal compulsory health insurance and competing providers. Dr James Reilly, the current Minister of Health and a former GP and president of the Irish Medical Organisation, claimed that "The coalition Government has embarked upon one of the most radical programmes of healthcare reform since the formation of the UK's NHS in 1948. Our goal is clear. To dismantle Ireland's unfair and inefficient two-tier model of healthcare and replace it with a comprehensive system of Universal Health Insurance (UHI)."

Specifically, Reilly and the Irish government are citing the Dutch healthcare system as their model, which was itself overhauled as recently as 2006 and has been ranked number one among health systems by both the Commonwealth Fund and Euro Health Consumer Index (EHCI). Irish policymakers have spent recent years consulting with Dutch policymakers and health experts on the system. Insurer competition in Germany's comparable healthcare system was also cited as an example in the Labour Party's pre-election health plan. The plan is intended to be fully implemented by 2020. If Ireland successfully completes this transition, this will be a significant event in Western health policy, as it will represent an example of a developed democracy with a long-established tax-financed healthcare system subsequently decentralising and switching over to the social insurance model. Therefore, Ireland's bold reforms could serve as an interesting case study for the UK, especially in light of the relative comparability our cultures, public health profiles and to a large degree our existing systems. These reforms are also being pursued despite, or perhaps because of, the difficult fiscal and economic situation the Republic faces. Furthermore, the leading role that the Irish Labour Party - a social democratic party with close ties to our own UK Labour Party - has taken in calling for a decentralised and social insurance-based universal system is notable, demonstrating that the principles of social solidarity and universal free care need not necessarily entail support for a centralised public monopoly structure over a social insurance-based system.

Therefore, both in terms of the relative comparability of its existing situation to ours and in terms of the unprecedented and consensus-based switch to social insurance it is embarking upon - a reform which Civitas has in past suggested as a potential option for our own system - Ireland offers a valuable emerging case study for the UK that is not to be ignored.

## Current Irish Health System

### Origins and Basic Structure

Ireland's basic healthcare system has some core features and a history that most British observers could recognise. The primary source of healthcare funding is general taxation, much of the country's hospital capacity has traditionally been under government ownership and their 'national health service' model is managed by centralised government authorities, though as in the UK, the exact structure of the health service has evolved over time in several top-down reorganisations.

There are of course inevitable design differences between the UK and Irish systems – The King's Fund noted that patient transfers from the UK to Ireland can be "problematic" due to the comparatively larger role private insurance and charging plays at the margins of the current Irish system, for example (see 'Current Financing Model' below).<sup>1</sup> But in the main, political scientists and health analysts tend to group the UK and Ireland together as tax-financed, 'Beveridgean' or 'national health service' nations in terms of our healthcare arrangements, in contrast with the 'Bismarckian' social health insurance (SHI) systems found on the continent that tend to feature a more direct contributory link, explicit cover, provider diversity and competition in core health services (the Netherlands, Germany and France are examples). For example, American political scientists George Ross and Andrew Martin explained that "the Anglo-Saxon model, found in the UK and Ireland, is guided by utilitarian market principles, with social protection that is highly inclusive though not fully universal, except for healthcare...Healthcare and social services are financed through general taxation".<sup>2</sup> In the 2012 Euro Health Consumer Index (EHCI), Swedish health expert Arne Björnberg characterised Ireland and the UK as having similar 'Beveridgean' single-payer systems and similar performance as a result - "countries who are known to have quite similar healthcare systems should be expected not to end up far apart in the ranking. This is confirmed by finding...Ireland and the UK clinging together", he argued.<sup>3</sup> A 1998 European Parliament report grouped the UK and Ireland together (along with Greece, Finland, Sweden, Italy and Spain) for how healthcare is financed and described our health systems as being "mainly provided by a publicly-financed health care system under central public control through which all inhabitants are entitled to health care benefits".<sup>4</sup> In 2007, two Dutch health researchers grouped Ireland and the UK together as Beveridgean or "National Health Service" systems, in a comparison with Bismarckian social insurance systems.<sup>5</sup> In 2012, the Organisation for Economic Co-operation and Development (OECD) classed Ireland, along with the UK, Hungary, Italy, New Zealand, Norway and Poland, as a "heavily regulated public system" among six health system categories.<sup>6</sup> Consistent with all these analyses, the Fine Gael party's reform proposal described Ireland and the UK as Beveridge nations (defining this as featuring a "centralised monopoly health service provider financed from taxation"), in contrast to the continental Bismarckian model and the inequitable, non-universal "Business" model in the US.<sup>7</sup>

In the 19<sup>th</sup> and early 20<sup>th</sup> centuries, healthcare arrangements in Ireland were often provided non-governmentally by Catholic charities, while the state mainly focused on basic services for the very poor and public health measures such as the regulation of clean water. The first

voluntary hospitals, established by Protestant and Quaker traditions, were established by 1753, while the first Roman Catholic hospital was established in 1834.<sup>8</sup> The Church ran many non-profit voluntary hospitals, similar to those that existed in the UK prior to the founding of the NHS, though unlike in the UK, these hospitals maintain a substantial role in the present day public healthcare system as taxpayer-financed autonomous public institutions, operating alongside the directly state-run hospitals (see 'Provision in the Current System' below).<sup>9,10</sup>

As in the UK and several other European nations, substantial changes in the Irish health system occurred in the post-war era. In 1946 Ireland passed the Ministers and Secretaries Act, which led to the establishment of Ireland's modern Department of Health in 1947 and nationalised public health services for the first time – previously, they had been handled by the separate Department of Local Government and Public Health (although local authorities nevertheless remained in control of the day-to-day running of health services until 1970). This was followed by the Health Act 1953, which granted access to hospital and specialist care to 85% of the Irish population. At this stage, the system was to some extent funded from work-related social insurance contributions, perhaps comparable to UK National Insurance in the pre-NHS era. In order to cater for the needs of the 15% not directly covered by the emerging state system at that time, however, in 1957 the government established the Voluntary Health Insurance (VHI) Board, a non-profit state-owned health insurance company (see 'Current Financing Model' below for more about this).<sup>11</sup>

The system went through further reforms in 1970, when much of the current design of the system came into being – these reforms have thus been referred to as “the blueprint for the modern Irish health care system”. General taxation became the primary source of funding, with all citizens being entitled to state-subsidised care – today Pay-Related Social Insurance (PRSI) constitutes only 1% of healthcare financing in Ireland (see 'Current Financing Model' below).<sup>12</sup> This followed Catholic Church pressure in the 1960s for the state to intervene more in health, education and welfare on social justice grounds.<sup>13</sup> Eight regional boards were established and control of the “development and execution of health policy” was taken away from local authorities and centralised in the hands of the Department of Health, completing the process that began in 1947 – emphasis was placed on the need to develop the acute hospital sector. These boards provided general hospital, special hospital and community care services and social and child care. However, the voluntary sector “continued to play a vital role in the delivery of health and personal social services” as well, independent of the regional boards and funded directly by the national Department of Health. Later, in 2000, one of the eight boards (the Eastern Board) was split into three sub-boards, due to coordination problems resulting from the disproportionate size of the Eastern region (1.4 million residents, compared to 200,000 to 580,000 in other regions). From the 1990s, data on quality of board-provided services was collected to allow performance comparisons to be made. Boards each had around 30 members, half of whom were elected local politicians nominated by the Irish counties, while three members would be appointed by the Department of Health to each board and the rest would be medical professionals. Each board had a CEO and a management team.<sup>14</sup> This regional board-based structure was comparable to how the English NHS has in the past been organised, or to how the devolved Scottish and Welsh NHS services are still organised today.<sup>15</sup> In 1998, the European Parliament commented that the system was “highly centralised”, due to the substantial planning and development role held by the Department of Health at the national level.<sup>16</sup>

## 2005 Reorganisation: the Health Service Executive

The 2004 Health Act put the system through a major reorganisation, abolishing the various health boards and centralising control of Ireland's health service under a single national authority called the Health Service Executive (HSE) in January 2005. This change was intended to "make the system more primary and community care driven, backed up by improved access to specialist, acute and long-stay services". This decision to reorganise the structure of the Irish health service and replace regional authorities with one national one is to some extent comparable with the abolition of the regional Strategic Health Authorities and the creation of the national non-departmental body NHS England under our own Health and Social Care Act 2012, although unlike the nominally politically-independent NHS England, the Irish HSE is "accountable directly to the Minister of Health". The HSE has a €13 billion budget and is Ireland's largest employer, employing over 100,000 staff - many HSE staff had previously worked for the regional boards. A government document stated that "At the heart of this transformation will be programmes that make it easier for people to access quality services and easier for the HSE to deliver these quality services". It also said that "At an operational level the biggest challenge facing the HSE is the speed with which reliance on hospitals can be reduced and capacity to deliver care within the community setting can be built", so integrated and responsive local community services were needed.<sup>17</sup> Many previously separate national health agencies were merged into the HSE, though the HSE still has some sub-agencies including the Mental Health Commission, the National Cancer Screening Service, the Irish Blood Transfusion Service and the Health Information and Quality Authority (created in 2007 and responsible for accreditation and for "developing health information, setting and monitoring standards, promoting and implementing quality assurance programmes nationally, and overseeing health technology assessment (HTA), including the consideration of cost as well as clinical effectiveness"). Under the HSE reorganisation, Local Health Offices (LHOs) were set up in each of the 32 counties, tasked with delivering community and primary care services and accountable to the HSE's Primary, Community and Continuing Care (PCCC) directorate. Hospital services are delivered by 10 hospital networks, based on the former regional board areas – these networks are accountable to the HSE National Hospitals Office (NHO). The HSE also has four "regional health offices", intended to facilitate feedback from patients and local representatives.<sup>18</sup>

Reactions to the new structure have been mixed, however. Initial polls in 2005 suggested there was "much public confusion about the new health structures".<sup>19</sup> In 2008 the authors of the Euro Health Consumer Index (EHCI), Arne Björnberg and Marek Uhlir, did comment that "The Health Service Executive reform seems to have started improving a historically dismal performance. The severe waiting list problems seem to be improving, and so are Outcomes. However, patient organisations do not seem to have discovered this."<sup>20</sup> However, there have also been criticisms of the new HSE's centralism and ineffectiveness (see 'Current Problems: The Case for Reform - Overcentralisation and Lack of Competition' below).

## Provision in the Current System

Much of healthcare provision in Ireland is provided by the state under the auspices of the HSE, much as in the NHS. However, though the HSE is the nation's single largest employer and the state remains a key source of provision in Ireland, pluralism is nevertheless somewhat greater than here.

As the Irish government's Citizens Information website explains, there are three types of hospital in Ireland:<sup>21</sup>

- HSE hospitals: these are fully owned by the state as part of the HSE and funded from general taxation
- Voluntary public hospitals: these are funded mostly by the government from general taxation, but are either run by private bodies (usually Roman Catholic orders) or are "incorporated by charter or statute and are run by boards often appointed by the Minister for Health"
- Private hospitals: fully private, for-profit and not funded from general taxation (though the private hospital sector has been indirectly subsidised with some tax incentives since 2001)

Citizens Information adds that "there is very little difference in practice between the first two types, both of which provide public services". Further, it also notes that both HSE and public voluntary hospitals often "also provide private health care but they must clearly distinguish between public and private beds" (much as how some British NHS trusts can earn some income from treating private patients).<sup>22</sup> Health insurance firms in Ireland sometimes categorise all voluntary hospitals as 'public' along with the HSE hospitals in their directories, with the fully private hospitals categorised separately.<sup>23</sup> In 2011, there were at least 57 acute hospitals in Ireland and there are over 10,600 inpatient acute public hospital beds.<sup>24,25</sup> There are 28 voluntary public hospitals – among them are university teaching hospitals, such as St James's Hospital in Dublin.<sup>26</sup> 21 private hospitals are represented by the Independent Hospitals Association of Ireland (IHA), which states that its members "operate almost one third of the hospitals in the country", providing "acute & mental health services throughout Ireland" – IHA member hospitals are "funded in the majority from non-State Governmental resources".<sup>27,28</sup>

A 1998 European Parliament working paper noted Ireland as a country in which state-controlled hospitals were a "dominant feature" of the health system, in contrast to the greater private provision role in France, Germany and Belgium. However, along with the UK and Portugal, Ireland was also noted as an example of a country in which "there have been recent developments allowing major hospital services a greater degree of freedom from state control", along the lines of the NHS Trusts introduced in the UK in the 1990s. That same paper also reported over 60% of acute hospitals were government-run (at that time by the pre-HSE regional Health Boards), 24% were public voluntary and 14% were private. In terms of the hospital types, Regional Hospitals, which provide "a comprehensive range of specialist services and are located in the major population centres", were 12% of hospital provision. General Hospitals, which provide "services for country catchment areas and have consultant-staffed units for general medicine, general surgery, obstetrics, gynaecology and paediatrics", made up 30%. The most common were District Hospitals, "small hospitals with 20-40 beds, staffed on a part-time basis by GPs for the provision of medical and minor surgical treatment". The report further noted that "some district hospitals have become homes for the elderly" and that many voluntary hospitals are general teaching hospitals, and are often specialised and associated with medical schools.<sup>29</sup>

### *Voluntary Public Hospitals*

The Economic and Social Research Institute in Ireland described the voluntary hospitals as follows: "Voluntary public hospitals, supported but not owned by the Health Boards [now the

HSE], are general hospitals that often function as teaching hospitals and are located mainly in Dublin and other large centres of population”.<sup>30</sup> The 28 voluntary public hospitals are concentrated in major cities, leaving public provision in the rest of Ireland to the HSE – 3 voluntary hospitals are in Cork, one is in Limerick and the remainder are in Dublin.<sup>31</sup> Roman Catholic orders also still have a role in the public voluntary hospital sector. For example, St Vincent’s University Hospital in Dublin, which bills itself as a “major academic teaching hospital” with “in excess of forty medical specialities”, was founded by the Religious Sisters of Charity in 1834.<sup>3233</sup> Another public voluntary, the Adelaide and Meath Hospital in Dublin, has Protestant ties, having been founded in 1839 to serve the poor Protestant community.<sup>34</sup>

The role of the Catholic Church is becoming controversial in some respects. In 2011, the website Irish Health commented that attitudes may be shifting against the involvement of the Catholic Church in healthcare provision, due to mistrust of Church-run facilities following child abuse revelations or a desire for a more secular mode of health provision.<sup>3536</sup> Recently, as Ireland has sought to revise its strict abortion laws following the death of a woman who had been refused an emergency abortion in October 2012, compliance with the new laws has been an issue for some Catholic hospitals.<sup>37</sup> A 1999 report on the third sector and civil society in Ireland also noted complexities in the relationship between the voluntary hospitals and the state, explaining that voluntary hospitals:

“are traditionally perceived as part of the public sector and while there has been some recent public debate about the statutory funding that such hospitals receive, there has been little explicit recognition that key to the relationship between the government and these voluntary hospitals (who provide a large proportion of health services, particularly in the Dublin area) is the fact that such organisations are private autonomous organisations. The autonomy of these hospitals can sometimes be a thorn in the side of government departments concerned because...these organisations are 'by the state' but not 'of the state' ...and control is, therefore, an issue”<sup>38</sup>

However, the continued role of civil society in health provision in the form of the public voluntary hospitals has benefits. Ireland’s voluntary hospitals are held in high regard. The European Observatory on Health Systems and Policies, part of the World Health Organisation, noted a “long and established tradition of care and service provision for people with intellectual and physical disabilities” among the voluntary hospitals, as well as the fact that state-funded non-profit hospital organisations have the advantage of being able to supplement their activities through voluntary fundraising. Further, a key difference between the HSE and voluntary public hospitals is that “any underspend or additional revenue generated by HSE hospitals in the financial year must be returned to the Exchequer”, whereas “These restrictions on financing...do not apply to the publicly funded voluntary hospitals, which remain free to retain additional revenue and any efficiency savings made”. Another report on relations with the third sector in 1998 noted that aside from the voluntary hospitals, and similar voluntary public schools in the education sector, there are few other examples of the government encouraging the voluntary sector in Ireland – they thus represent a powerful commitment to civil society on the part of the Irish government.<sup>39</sup> The 2011 Hospital In-Patient Enquiry (HIPE) scheme, organised by The Economic & Social Research Institute, found that in the voluntary hospitals, average length of stay (ALOS) for acute in-patients was 5.6 days for public patients and 5.8 days for private patients, while for HSE-run regional hospitals, average length of stay for both was 4.2 days.<sup>40</sup> While the Irish government is aiming to reduce lengths of stay in line with European-wide reductions in ALOS, higher lengths could also demonstrate the voluntary public hospitals being



more thorough with patient care or facing fewer central budgetary pressures – private patients being treated for longer suggests this. A 2009 Fine Gael party health policy document defended the voluntary hospitals, stating that “evidence from other countries is that these independent, not-for-profit hospitals tend to do best”, potentially because “the caring ethos of not-for-profit hospitals leads to higher quality treatment and greater trust among patients”.<sup>41</sup>

### *Private Provision and the National Treatment Purchase Fund (NTPF)*

As in the UK, independent for-profit private hospitals “are not included within the publicly reimbursed health system and therefore are largely dependent on income from [private health insurance]”.<sup>42</sup> Recent data has revealed that patient satisfaction in private hospitals was higher than in public (HSE or voluntary) hospitals. Though 89% of public patients rated their experiences as either “excellent”, “very good” or “good”, among private hospital patients this figure was 99.5%, with a clearer skew towards “excellent” (79.5% of private patients said “excellent”, compared to 26% of public patients). However, the researchers also noted possible attitudinal differences between public and private users and stated that “there is nothing to suggest that clinical quality or outcomes have any bearing on this finding”.<sup>43</sup> In the 2000s, there was an increase in the number of beds in the private hospitals, a shift supported by Bertie Ahern’s coalition government under what was called the “co-location” policy. The aim of this policy was to transfer the 20% of public hospital beds reserved for private use directly to private hospitals and “free up public beds by building private hospitals within the grounds of existing public hospitals”. After an initial policy providing tax incentives for the private health sector in 2001, Minister for Health and Children Mary Harney pushed these policies further after her appointment in 2004. In 2007, six new private facilities with 914 beds were announced.<sup>44</sup> These policies drew criticism, however, with critics such as Cork Institute of Technology economist Tom O’Connor and the Irish parliamentary Joint Committee on Health and Children warning that private hospitals were heavily reliant on state-funded hospitals for consultants and up to 75% of provision in any case.<sup>45</sup> In 2010, the news website Irish Health reported that there had been relatively little progress with the co-location policy and in 2011, the incumbent government announced that in light of difficulties, it would “not pursue a policy of co-location” beyond four existing contracts that had already been signed.<sup>46,47</sup>

Perhaps a more positive move was the establishment of the National Treatment Purchase Fund (NTPF), introduced as part of Ireland’s 2001 National Health Strategy. This is a government fund that will pay for private treatment – either in the private beds of a HSE/voluntary hospital or in an independent private hospital – for a public patient who has been waiting for longer than a legally defined period. These standards were 12 months for a first time outpatient appointment, 8 months for inpatient or day case treatment, 20 weeks maximum for paediatrics and 13 weeks for a GI endoscopy. The NTPF had an initial budget of €30m, later increased to more than €90m. The NTPF can even be used to pay for treatment for Irish nationals in hospitals in the UK (this built on a long-standing Irish government policy of funding treatment in the UK for certain specialist services Irish hospitals were unable to perform – the Freeman NHS Hospital in Newcastle has performed rare heart-lung transplants for Irish patients, for example).<sup>48</sup> The aim of this policy is therefore comparable to the waiting time guarantees, private referrals and NHS Independent Sector Treatment Centres (ISTCs) introduced in the NHS by New Labour, aimed at reducing waiting times, increasing available capacity and exerting a measure of competitive pressure on existing providers – however, with the exception of NTPF cases the clear public/private split in the system remains in effect.<sup>49</sup> Ireland did see notable waiting time decreases between when the policy was introduced in 2002 and 2009.<sup>50</sup> However, problems

have been exposed with consultants referring NTPF patients to themselves, in breach of rules banning such conflicts of interests.<sup>51</sup>

A specific part of the NTPF established in June 2011, the Special Delivery Unit for Unscheduled Care, aims to enforce waiting times of 6 to 9 hours for all Emergency Department (Accident & Emergency) patients.<sup>52</sup> In July 2011, further changes were made to the role of the NTPF, which the body's official website noted were "another stage in the implementation of the Government's health reform agenda and follow on from the establishment of the Special Delivery Unit", referring to the current coalition's Universal Health Insurance reforms (see 'Universal Health Insurance (UHI): A New Beginning?' below).<sup>53</sup>

### Primary Care

General Practitioners (GPs) play a key role in the Irish healthcare system. As in the UK, they are both a part of the public health system and independent from it, as they are effectively independent contractors and reimbursed by the state when they treat public patients. The HSE also contracts GPs to provide public maternity, infant and vaccination services.<sup>54</sup> Some Irish GPs exclusively treat either public or private patients, but most treat both. They also set their own fees on a fee per service basis (see 'Current Financing Model' below for more detail).<sup>55</sup> In 2005, there were 2128 GPs employed in Ireland. Ireland does however have the lowest rate of GPs per 1,000 in the OECD and its primary care infrastructure was described as "relatively poor" by the European Observatory on Health Systems and Policies.<sup>56</sup>

### Current Financing

As outlined above, healthcare in Ireland is currently predominantly funded from general taxation - the system can thus be roughly classified as a Beveridgean model, alongside those of the UK, the Nordic countries, Mediterranean Europe and New Zealand. The European Observatory on Health Systems and Policies described the system as remaining "predominantly tax funded" and noted that in 2006, 78.3% of total health expenditure was raised from taxation, pay-related social insurance (PRSI, similar to UK National Insurance) and other government sources, such as excise duties.<sup>57</sup> According to the OECD, by 2011 public funding had declined somewhat to 67%, however, in contrast to 82% of health expenditure remaining public in the UK.<sup>58</sup> Since January 2011, an income-related Universal Social Charge (USC) has been a healthcare-related tax in Ireland; those earning less than €10,036 are exempt from the tax, a 4% rate of USC is paid by those earning less than €16,016 and a 7% rate is paid for those earning over €16,016.<sup>59</sup> However, even under the current pre-reform HSE system, there are some differences in financing between the UK and Irish systems.

### Coverage Categories

Since 1972, tax-financed public cover has been based on two categories of eligibility under the HSE General Medical Service (GMS) system, Category 1 (full eligibility) and Category 2 (partial eligibility). Category 1 residents, previously around 30% of the population, are issued with a 'Medical Card', guaranteeing them free at the point of use GP and hospital care.<sup>60</sup> Prescriptions were previously free for Category 1 residents, but a €0.50 prescription charge was introduced in 2010, subject to a €10 monthly cap.<sup>61</sup> Cards are issued to over 70s (though now only if earning less than €500 per week, due to post-crisis austerity measures<sup>62</sup>) and under 70s on low-incomes, defined as an income of less than €164-266.50 a week depending on exact personal

circumstances (slightly higher income thresholds exist for those aged 66-69 or families/single parents with children).<sup>63</sup> Category 2 residents – previously around 70% of the population – are entitled to public hospital care, but must pay fixed ‘hotel’ charges of €75 for out-patient and in-patient bed days and €100 for A&E treatment without a referral. There is however a yearly cost ceiling of €750 for in-patient treatment. If their monthly expenditure on prescriptions exceeds a limit of €120, they can also receive free prescriptions from the Drugs Payment Scheme. Category 2 sufferers of certain chronic conditions are also exempted from all prescription charges.<sup>64</sup> Cover for primary care is minimal and Irish GPs set their own fees – charges can range from €35 to €80 a visit. This category divide has been described as “unusual in a European context”.<sup>65</sup> ‘GP Visit Cards’, guaranteeing government-funded free GP care for certain Category 2 patients, were introduced in 2005 for people earning less than €246-€400 a week (additional allowances for children and higher thresholds for those aged 66-69 or over 70 again exist). In 2007, 2% of the population carried Visit Cards.<sup>66</sup> Private patients in public hospitals pay higher fees, meanwhile, ranging from €222 to €1,046 per day based on the hospital and type of treatment with no exemptions available, though these fees are again capped at €750 per year.<sup>67</sup>

The severe economic recession Ireland has faced following the 2008 financial crisis and the onset of the Eurozone crisis have impacted somewhat upon these structures - unemployment and reduced incomes pushed the share of the population eligible for Medical Cards closer to 41% of the population. However, the simultaneous need for cuts in public expenditure led the government to tighten the eligibility criteria for the Medical Card, which arrested further rises above this level that would have occurred otherwise.<sup>68</sup> Recently, the Irish government has been criticised by the Irish Medical Organisation for a drive to take away ineligible and redundant Medical Cards, due to implications for access.<sup>69</sup>

### *Private Health Insurance*

Another way in which the predominantly tax-financed Irish system departs from the UK NHS model is the role of voluntary private health insurance (PHI). In the UK, around 10% carry private health insurance and its role has been defined by the OECD as mainly “duplicate”, meaning insurance mainly “offers coverage for health services already included under government health insurance, while also offering access to different providers (e.g., private hospitals) or levels of service (e.g., faster access to care)”.<sup>70</sup> Meanwhile, until recently in Ireland, around half the population carried private voluntary health insurance. This insurance mainly serves the same duplicative function of securing faster access to the same services the HSE provides, either in private beds in public hospitals or in the for-profit independent hospitals, and is also similar insofar as Irish voluntary insurance “does not exempt individuals from contributing to government health coverage programmes” (private insurance holders still pay the taxes that fund the HSE, just as British private insurance holders simultaneously pay taxes and National Insurance to fund the NHS) – this accounts for 87% of the Irish private insurance market.<sup>71</sup> However, some voluntary health insurance plans have secondary complementary (covering co-payments) and supplementary (covering services excluded from public coverage) functions, due to the user charges that Category 2 residents face. In 2004, 62% of Category 2 residents (43% of the population) carried insurance, while only 13% of elderly and low-income Category 1 residents (4% of the population) did.<sup>72</sup> However, a 2009 Fine Gael health document stressed that insurance is still not to be seen as “key” within Ireland’s Beveridge model structure, as in common with the UK and in contrast to the entirely insurance-based Dutch system, the main role of insurance is to allow some individuals to “jump the queue”.<sup>73</sup> It is also

true that as in the UK, “In Ireland, private hospitals are not included within the publicly reimbursed health system and therefore are largely dependent on income from PHI”.<sup>74</sup>

It has been longstanding Irish government policy to intervene in the private insurance market in order to somewhat boost accessibility. In 1957, the government established the Voluntary Health Insurance (VHI) Board, a non-profit state-owned insurance company whose board members were appointed by the Department of Health (the board now trades as “Vhi Healthcare”, but is commonly known as “the VHI”). The VHI was founded to ensure that those not eligible for full free care on the public health system would still have coverage, and has long dominated the private insurance market in Ireland. In the 1990s, partly due to concerns that the VHI’s dominance was breaching EU competition law, the insurance market was opened to greater competition, after which a variety of private providers increased their market share, though in 2006 the VHI represented 75% of the market and in December 2009 it still had a 65.5% share.<sup>75</sup> Currently Laya Healthcare (formerly Quinn Healthcare), Hibernian Aviva, GloHealth and HSF Health Plan are the main private insurers – in 2009, Quinn Healthcare had a market share of 24% and Aviva had a market share of 11%.<sup>76</sup> However, the VHI tends to take on more older-age policyholders and these customers use hospitals more – as a result, VHI executives reported in 2010 that disproportionate to its market share, the VHI funds 82% of privately-funded care.<sup>77</sup> The British insurer BUPA entered the Irish market in 1997, but later withdrew in 2006. In May 2010, the Irish government announced plans to privatise the VHI, but these plans were reversed by the incoming coalition government following the February 2011 election, as the VHI will instead be retained as a state-owned “public option” in the coalition’s new Universal Health Insurance reforms (see ‘Universal Health Insurance (UHI): A New Beginning?’).<sup>78</sup>

In 2001, a Health Insurance Authority (HIA) was established to regulate the market, review practices, promote competition and ensure that open enrolment, lifetime cover and community rating (meaning all people should pay the same insurance premiums regardless of age, sex or health status) are guaranteed for Irish consumers – no one in Ireland can be refused health insurance on grounds of risk.<sup>79</sup> In 2006, the Irish government introduced risk-equalisation, to be enforced by the HIA, meaning “a process that aims to equitably neutralise differences in insurers’ costs that arise due to variations in the health status of their members” in order to ensure that older or less healthy consumers and their insurers were not disadvantaged in the health insurance market. This would have involved insurers that took on more young customers having to make payments to insurers with an older customer base.<sup>80</sup> It was this policy, later vetoed by the Irish Supreme Court in 2008, that prompted BUPA Ireland’s withdrawal from the insurance market in 2006.<sup>81</sup> In January 2013, the Irish government’s reworked Permanent Risk Equalisation Scheme was approved by the EU Commission.<sup>82</sup>

In 2007, 51% of Irish people carried private health insurance, an increase from 45% reported in 2001.<sup>83</sup> Descriptions of the Irish health system written a few years ago will commonly state that around half of Irish people have health insurance, therefore. However recently, a combination of the post-2008 recession and price rises imposed by Ireland’s main health insurance companies have cost many Irish residents their insurance cover – in 2012, 210 policies were being cancelled a day and only 44.9% had coverage (separate figures suggested it may have fallen to 35% in 2012 and 34% in 2013).<sup>8485</sup>

## Current Problems: The Case for Reform

The current Irish health system is plagued by a variety of problems, some of which are comparable to problems we face in the UK and which, taken together, have inspired the Irish coalition government's radical UHI plans.

### Rationing and Underfunding

Despite repeated efforts to reduce them, including the National Treatment Purchase Fund (NTPF) and the Special Delivery Unit, waiting times have long been a major concern in the Irish health system. In 2001, a survey of public attitudes found that "59% believed that waiting times in the public system had increased over the previous three years" (70% in Dublin). Lower income people were also more likely to perceive waiting times as a problem, demonstrating an equity gap in access to timely treatment.<sup>86</sup> Data from the Central Statistics Office in 2007 suggested that despite the founding of the NTPF as part of the 2001 National Health Strategy, waiting times remain an issue.

More recently, the economic crisis and austerity have complicated matters further. In October 2010 more than 20,000 public hospital patients were forced to wait for longer than the stipulated three month target, an 11% increase from the previous year.<sup>87</sup> In July 2013, it was reported that the number of people waiting over a year for surgery had jumped from just 36 to 931 in the space of six months and that 48,279 were on waiting lists for inpatient or day-care, up from 41,732 the previous year. 20% of children were waiting longer than the set target of 20 weeks for treatment.<sup>88</sup> In May, it was reported that 377,000 were waiting for outpatient treatment, including 100,000 waiting more than the set target of 12 months – access to orthopaedics, ear, nose and throat, and ophthalmology were particular problems.<sup>89</sup> A September 2013 examination of waiting time monitoring across different countries also suggested that government targets in Ireland for elective surgery waits are also less stringent than in some other nations. In Ireland, the target for elective surgery is 2.5 months (75 days), compared to a target of 35 days in England, 33 in France, 34 in Australia, 30-60 days in Sweden and 61 in Spain, while the 3 month (90 day) target in Ireland for hip replacement surgery waits is significantly higher than equivalent targets in England (78 days), Sweden (30-60 days), the Netherlands (49-56 days), Denmark (58 days) and Canada (42 days in some provinces).<sup>90</sup> In June 2013, it was reported that not only had complaints risen in the HSE by almost a third, but that only 69% were dealt with within 30 days in line with official targets.<sup>91</sup> The 2013 OECD 'Health at a Glance' study found that "After years of steady decline, average waiting times for some operations in Portugal, Spain, England, and Ireland show a small increase". UK waits, while better than other nations following improvements in the 2000s, were higher than those of the Netherlands, for example.<sup>92</sup>

Health expenditure in Ireland is also low by continental standards – this has in particular been the case since the financial crisis, but was a problem even before it. Below is recent OECD health expenditure data on Ireland, the UK and the two high-performing continental health systems countries mentioned by the Irish coalition parties in their UHI reform plans, the Netherlands and Germany.<sup>93</sup> OECD averages are also given.

Healthcare financing data for the Republic of Ireland, the UK, the Netherlands and Germany, plus OECD averages (Source: OECD Health Data 2013)					
	Ireland	UK	Netherlands	Germany	OECD
Total expenditure on health, as a percentage of Gross Domestic Product (GDP)	8.9	9.4	11.9	11.3	9.3
Total expenditure on health, per capita (US\$, adjusted for purchasing power parity)	3699.5	3405.5	5098.9	4494.7	3339.0
Annual growth rate of total expenditure on health, in real terms	-3.0	-0.4	-0.1	1.1	4.1
Annual growth rate of public expenditure on health, in real terms	-6.6	-1.2	3.6	0.7	4.2
Public expenditure on health, as a percentage of total expenditure on health	67.0	82.8	85.7	76.5	72.2
Public expenditure on health, per capita (US\$, adjusted for purchasing power parity)	2477.3	2821.1	4054.9	3436.3	2426.7
Out-of-pocket payments (households), as a percentage of total health expenditure	18.1	9.9	6	13.2	19.6
Out-of-pocket payments (households), per capita (US\$, adjusted for purchasing power parity)	668.6	338.3	282.4	593.4	563.0
Pharmaceutical expenditure, as a percentage of total health expenditure	17.5	11.4 (2008)	9.4	14.1	16.4
Pharmaceutical expenditure, per capita (US\$, adjusted for purchasing power parity)	647.7	374.6 (2008)	479.3	632.6	498.0

Figure 1: OECD Health Data 2013 data on Irish and UK health financing. OECD average and German and Dutch figures given for comparison (Source: 'OECD Health Data 2013 – Frequently Requested Data')<sup>94</sup>

As we can see, Ireland's health expenditure as a percentage of GDP is low by OECD and UK standards, and while Irish per capita spending is higher than in the UK, it is still low compared to the Netherlands and Germany. Accounting for the Netherlands' older population, the spending gap between the Netherlands and Ireland (or the amount needed to construct a Dutch-inspired system in Ireland) may not be as much as direct comparisons of each nation's health spending would suggest, however.<sup>95</sup> This is likely not helped by the severe reductions in both overall and public health spending the Irish are seeing due to the post-crisis economic and fiscal situation – *New Statesman* writer David Cronin claimed "Ireland is second only to Greece in terms of the scale and speed of health cutbacks undertaken by "developed" countries", noting €3bn worth of cuts made to the HSE since 2008.<sup>96</sup> Public expenditure accounts for significantly less of health expenditure in Ireland, in turn placing far more of a burden on the Irish public in terms of out-of-pocket (OOP) costs and private insurance. The gap between public (tax or social insurance-funded) and OOP health expenditure – which adds up to around 14.9% in Ireland and 7.3% in the UK – accounts for the costs borne by private insurance.

OECD data suggests Ireland has slightly fewer doctors than Germany, the Netherlands or the OECD average. The data also suggests that CT and MRI exams are performed less often in Ireland when compared to other nations, perhaps suggesting access to technology may be rationed. In Ireland, there are 18.3 MRI exams performed per 1,000 people, compared to 41.4 in the UK and an OECD average of 48.1. Similarly, 75 CT exams are performed per 1,000 in the Republic, compared to 77.5 in the UK and an OECD average of 127.9.<sup>97</sup> A 2005 study entitled 'A pan-European comparison regarding patient access to cancer drugs' found that patient access to cancer drugs in Ireland, while slightly better than in the UK, was worse than in other European nations including Spain, Switzerland, Belgium, the Netherlands and Austria. Uptake in Ireland was particularly low for Trastuzumab (breast cancer), Irinotecan (colorectal cancer) and Capecitabine (colorectal and breast cancer), for example.<sup>98</sup>

A 17-country study released in 2011 did find that Ireland was the most cost-efficient health system (the most productive proportional to spending put in), with the UK the second-most cost-efficient. However, these laudable achievements can perhaps be taken in part in the context of the proportionately lower spending in the UK and Ireland.<sup>99</sup> In a 2000 book exploring NHS rationing, Civitas contributor Heinz Redwood did comment that "International comparisons tend...to demonstrate that, at least in terms of productivity, the NHS is a relatively efficient organisation. It also produces reasonably good results with its very limited resources", which would appear to apply to Ireland as well. However, in light of the underfunding and rationing both systems experience relative to the continent, it is clear that more funding is required.<sup>100</sup>

Writing for the IMPACT trade union in Ireland, independent researcher Dr Jane Pillinger concluded that “We probably hear the word ‘crisis’ too much, but there certainly is a crisis in Ireland’s healthcare system. The health system remains unable to meet the health needs of the population because of historical underfunding (notwithstanding a short ‘blip’ in the economic boom years), perennial and growing HSE deficits [and] long waiting times for many services”.<sup>101</sup>

### Inequitable Access

Ireland’s somewhat convoluted approach of relying primarily on tax financing and central public administration, but with the two categories of public subsidy and with a substantial share of the population being able to jump queues if they have private insurance, has led to common objections that the health system in Ireland is tiered and inequitable.

The European Observatory on Health Systems and Policies has stated that “Promoting equity within the health system is likely to remain a critical concern. Access to the primary care system tends to be pro-poor, in that services are free for this group, while the remaining 70% of the population who do not qualify for free primary care must pay the substantial cost of general practitioner (GP) fees out of pocket. In contrast, in the secondary care sector, those who can afford private health insurance can avoid waiting for treatment.”<sup>102</sup> A 2007 cross-sectional study of GP visitation in Ireland found that “In the Republic of Ireland, 18.9% of patients (4.4% of non-paying patients and 26.3% of paying patients) had a medical problem in the previous year but had not consulted the doctor because of cost”, compared with only 1.8% of patients in Northern Ireland, which they noted has similar mortality and morbidity data to the Republic. The researchers concluded that “the deterrent effect of the consultation charge was most evident in patients in the middle of the income range”, a pattern “to be expected given that, at higher incomes, the cost is a relatively weak disincentive while those with lower incomes are protected by the GMS safety net” - they noted that “Amongst the paying patients, it is those that are poorest and those in the worst health who are most affected by the consultation charge”. Noting the argument that “Proponents of consultation charges argue that they make consumers more cost conscious, and therefore discourage ‘unnecessary’ utilisation”, the researchers ceded this “is a problem”, but also said that “it has been shown that a consultation charge is a rather blunt instrument which is as likely to reduce appropriate as inappropriate consultations”.<sup>103</sup> Another study of health utilisation in Ireland similarly found that although use of hospital services was correlated to some extent with need and age, “Having a medical card increases the number of days in hospital as does having medical insurance”.<sup>104</sup> This suggests that many working-age residents in the middle of the Irish income spectrum who are neither old or poor enough to be eligible for free Medical/GP Visit Card treatment nor able to afford health insurance are disadvantaged in the current Irish system – 25% of the Irish population had neither in 2007.<sup>105</sup> Access to specialists and dental services has also been found to skew “pro-rich” in Ireland compared to other OECD nations.<sup>106</sup>

Equity problems specifically relating to out of pocket costs are generally not much of an issue in the UK due to the free at the point of use principle that underpins the NHS - research by the Commonwealth Fund published in November 2013 found that the UK had the fewest number of people reporting cost-related access problems or problems paying medical bills out of 11 OECD nations.<sup>107</sup> However, it has been reported that small numbers of citizens of the Republic of Ireland occasionally engage in ‘health tourism’ in Northern Ireland, registering at addresses in the North to gain fraudulent access to free at the point of use GP services – there have been 108 known cases of this since August 2012.<sup>108</sup> Therefore, the lack of equitable access to care in the

Republic may be at the root of a problem, albeit a very limited one, faced by part of the UK.<sup>109</sup> More directly relevant to the UK is the apparent reality in Ireland that those on higher incomes who can afford duplicative private insurance or private treatment are more able to access better care and avoid HSE waiting times. This is the case in the UK as well, where the small 10% share of the population who have insurance or can otherwise afford to go private have privileged access and can avoid NHS waiting times.

### Centralisation and Lack of Competition

Another set of problems noted in Ireland relates to overcentralisation and bureaucracy in the HSE and a lack of competition between providers in various parts of the health system.

In 2008, a former CEO of one of the pre-2005 health boards argued that while the 2005 HSE reorganisation had been needed, there was a lack of “clarity around authority and responsibility” and the reforms needed to be more carefully implemented and communicated. The former CEO, Health Management Institute of Ireland president Denis Doherty, also argued that the new structures were over-centralised, saying that “Two hundred years ago Edmund Burke said when you centralise services you give rise to command and control structures and that has been the experience with the HSE” and that while some issues needed national planning (including cancer services, hospital policy and primary care strategy), many others should have been left to local discretion. He also identified a “bunker mentality” of resistance to change among HSE staff as another problem and felt the HSE was perceived as being too bureaucratic.<sup>110</sup> Some of Doherty’s criticisms are similar to ones that are sometimes voiced about the administration of our own NHS. Attacks on HSE bureaucracy and centralism have also come from health organisations, such as the Irish Nurses and Midwives Organisation (INMO), which has criticised the centralised approach to staffing decisions and budget control in the service. Reminiscent of some of the problems witnessed at Mid Staffordshire in the UK, the INMO has argued that “evidence shows that at times of major restructuring in large public organisations, bullying and intimidation increase, an approach that puts nurses and patients at risk. The management policies of the HSE view health as an exercise in controlling budgets, with no regard to the human costs”.<sup>111</sup>

Further, criticism has also come from several political parties, on both the left and right of Irish politics. In 2008, Fine Gael leader and now-Prime Minister Enda Kenny described the service as “bloated, over-centralised and disconnected from the patients it is supposed to serve”.<sup>112</sup> The Irish Labour Party’s 2011 health policy document attacked centralised, unaccountable management in the HSE, stating that “The HSE’s management of the health services has been unaccountable even to elected representatives in Dáil Eireann [the lower house of the Irish Parliament]. Top-heavy, bureaucratic management has become a feature of the HSE’s operation from the outset” and said that Ireland has “all the costs of running a bureaucratic public health care system”.<sup>113</sup> The left-wing Sinn Féin has commented that “the highly centralised approach of the Government and HSE management to healthcare delivery is failing. Democratic accountability and policy change are needed for real reform to take place” (though their reform approach diverges from that of Fine Gael and Labour).<sup>114</sup>

In 2012, the OECD published an overview of competition and local independence in hospital services in Ireland, the UK and variety of other nations. It noted that “The extent to which hospital managers have autonomy to hire and fire staff is a key supply side factor in influencing the capacity for hospitals to compete on efficiency and quality”, but found that while in 20



nations “hospital managers have complete autonomy in recruiting medical staff”, Ireland was one of nine in which “central or local governments make decisions about medical staff recruitment”. It was one of seven where central or local level government, rather than autonomous hospitals (21 nations), make decisions about recruiting health professionals. Ireland, along with the UK, Hungary, Italy, New Zealand, Norway and Poland, was also classed by the OECD as a “heavily regulated public system”, at the more centralised end of six health system categories they drew up. This means that:

“The budget constraint is more stringent than in most other OECD countries. Compared with previous group [Group 5, “health care is mainly provided by a heavily regulated public system” - Denmark, Finland, Mexico, Portugal and Spain], the possibility for patients of choosing between providers tends to be large and sub-national government autonomy tends to be lower. Over-the-basic coverage is very limited, except in Ireland and New Zealand, where duplicative coverage is significant and provides faster private-sector access to medical services.”

The OECD also reported on what kinds of comparative quality information is provided to patients, something which is vital for facilitating informed patient choice and true competition. In Ireland, no information existed for consumers on the prices of providers’ services. The Irish government does publish hospital provider quality information on clinical matters (covering outcomes measures and/or processes of care), but the OECD noted that in Denmark, Germany, New Zealand, Norway, the Slovak Republic and the UK, four types of information were being made available to consumers (clinical outcomes, appropriate processes, patient satisfaction and patient experience).<sup>115</sup>

In 2011, Trinity College Dublin and Harvard Medical School researcher Padhraig Ryan presented a working paper to the Trinity College Centre for Health Policy and Management, entitled ‘Transforming primary care in Ireland: information, incentives, and provider capabilities’. Ryan started by discussing the nature and potential benefits of provider competition within healthcare systems:<sup>116</sup>

“A few disparate points on the role of markets bear emphasis. First, arguments in favour of competition may blur with arguments for patients’ right to access clinical performance information, as public performance reporting serves to inform patients and hold providers accountable as well as facilitating provider competition on the basis of quality of care. Second, although intimately associated with privatisation, competition can be instilled among public sector providers. Thus the debate on competition can transcend the public-private debate. Third, although many forms of competition have exerted damaging effects on equity (fairness), this is not inevitable, and policy makers can carefully design market mechanisms to mitigate this risk. Moreover, it is conceivable that by increasing efficiency and quality, competition could benefit those worst-off in society by enhancing access to high-quality services. Fourth, competition can be instilled at multiple levels of a health system such as between primary care centres, hospitals, or insurance companies, and policy makers should carefully analyse at which (if any) level net beneficial effects are most likely”

Ryan also noted the transformation that market mechanisms can bring about in ailing public healthcare systems under certain circumstances, such as the Veterans Health Administration in the US, where “fostering competition between regional directors and quasi-market pressure built upon fear of replacement by the private sector” were supplementary factors in driving forward plans for improvement. Ryan therefore recommended pilot trials in performance

measurement in Irish primary care, amongst other measures, in order to induce greater competition in the Irish system.<sup>117</sup>

## Outcomes

Health outcome data made available by the OECD, *The Lancet* Global Burden of Disease 2010 study and the US-based Commonwealth Fund has made clear that Ireland, though perhaps slightly better than Britain, has room to improve on certain key measures. First, we will look at the OECD's outcome data.

Health Outcomes (Sources: OECD)	UK	Ireland	Netherlands	Germany	OECD
Life expectancy at birth, years	81.1	80.6	81.3	80.8	80.1
Infant mortality, deaths per 1,000 live births	4.3	3.5	3.6	3.6	4.1
Potential years of life lost, years lost per 100,000 females aged 0-69	2537.3	2197.3	2277	2218.8	2415
Potential years of life lost, years lost per 100,000 males aged 0-69	3992.2	3742.8	3193.7	4030.1	4632.6

Figure 2: OECD Health Data 2013 on Irish and UK health outcomes. OECD average and German and Dutch figures given for comparison (Source: 'OECD Health Data 2013 – Frequently Requested Data')<sup>118</sup>

Population Health factors (Sources: OECD)	UK	Ireland	Germany	Netherlands	OECD
Obese population, percentage of total population (2007 data)	24.0	23.0	N/A	N/A	18.2 (8 countries)
Obese population, percentage of total population (2007 data)	N/A	15.0	13.6 (2005)	11.2	15.3
Alcohol consumption, Litres per capita (age 15+)	10.0	11.6	11.7 (2009)	9.4 (2009)	9.4
Tobacco consumption, percentage of population 15+ who are daily smokers (2007 data)	21.0	29.0	21.9 (2009)	23.1	20.6
Intentional self-harm deaths (suicides) per 100,000 population	6.7	11.0	10.8	9.2	12.6

Figure 3: OECD Health Data 2013 on Irish and UK population health measures. Most recent or relevant available data used, OECD average and German and Dutch figures given for comparison (Source: 'OECD Health Data 2013 – Frequently Requested Data')<sup>119</sup>

As we can see, there are also some similarities between the population health profiles of the UK and Ireland, though there do not appear to be significant differences between the two 'Beveridgean'/Northern European nations (Ireland and the UK) and the two 'Bismarckian'/continental comparators (the Netherlands and Germany), at least according to the limited OECD data available. British Northern Ireland is a particularly close comparator for the Republic of Ireland in terms of mortality and morbidity data, some researchers have noted.<sup>120</sup> In December 2010, a study entitled 'Health at a Glance: Europe 2010' found Britain and Ireland to be the most obese of 27 European nations; in the UK, 24.5% of adults were clinically obese, while Ireland was a close second with 22.3%. Norway, Sweden, the Netherlands, France and Denmark had the lowest obesity rates.<sup>121</sup>

Conditions	UK	Ireland	Germany	Netherlands
Ischaemic Heart Disease	14	16	15	4
Stroke	13	10	6	9
Lung Cancer	12	9	10	18

<b>Lower Respiratory Infections</b>	<b>18</b>	<b>17</b>	<b>9</b>	<b>13</b>
<b>COPD</b>	<b>17</b>	<b>13</b>	<b>10</b>	<b>15</b>
<b>Breast Cancer</b>	<b>18</b>	<b>15</b>	<b>11</b>	<b>17</b>
<b>Colorectal Cancer</b>	<b>9</b>	<b>15</b>	<b>10</b>	<b>17</b>
<b>Self-Harm</b>	<b>4</b>	<b>13</b>	<b>8</b>	<b>5</b>
<b>Road Injury</b>	<b>4</b>	<b>7</b>	<b>5</b>	<b>2</b>
<b>Stomach Cancer</b>	<b>8</b>	<b>13</b>	<b>16</b>	<b>11</b>
<b>Congenital Anomalies</b>	<b>16</b>	<b>19</b>	<b>6</b>	<b>12</b>
<b>Preterm Birth Complications</b>	<b>18</b>	<b>12</b>	<b>13</b>	<b>8</b>
<b>Other Cardiovascular/Circulatory</b>	<b>14</b>	<b>9</b>	<b>16</b>	<b>13</b>
<b>Cirrhosis</b>	<b>11</b>	<b>7</b>	<b>16</b>	<b>2</b>
<b>Pancreatic Cancer</b>	<b>4</b>	<b>9</b>	<b>15</b>	<b>11</b>
<b>Diabetes</b>	<b>1</b>	<b>5</b>	<b>11</b>	<b>13</b>
<b>Oesophageal Cancer</b>	<b>19</b>	<b>17</b>	<b>12</b>	<b>16</b>
<b>Prostate Cancer</b>	<b>11</b>	<b>15</b>	<b>7</b>	<b>14</b>
<b>Aortic Aneurysm</b>	<b>18</b>	<b>12</b>	<b>4</b>	<b>14</b>
<b>Non-Hodgkin Lymphoma</b>	<b>17</b>	<b>14</b>	<b>3</b>	<b>10</b>
<b>Leukaemia</b>	<b>8</b>	<b>4</b>	<b>10</b>	<b>11</b>
<b>Ovarian Cancer</b>	<b>16</b>	<b>18</b>	<b>11</b>	<b>15</b>
<b>Brain Cancer</b>	<b>6</b>	<b>9</b>	<b>4</b>	<b>13</b>
<b>Alzheimer's Disease</b>	<b>11</b>	<b>6</b>	<b>3</b>	<b>13</b>
<b>Bladder Cancer</b>	<b>9</b>	<b>4</b>	<b>12</b>	<b>16</b>
<b>Falls</b>	<b>8</b>	<b>13</b>	<b>9</b>	<b>4</b>
<b>Chronic kidney disease</b>	<b>3</b>	<b>12</b>	<b>15</b>	<b>6</b>
<b>Kidney cancers</b>	<b>6</b>	<b>4</b>	<b>16</b>	<b>15</b>

**Figure 4: Rankings for age-standardised Years of Life Lost (YLLs) for specific conditions (Lancet National Performance Rank, 2010) (Source: Global Burden of Disease Study 2010)<sup>122</sup>**

The above chart details the relative position of Ireland and the UK in terms of Years of Life Lost (YLL) for 28 conditions listed by the Global Burden of Disease Study 2010 published in *The Lancet*, which compared the original 15 members of the European Union, Australia, Canada, Norway and the USA (the EU15+). The UK outperforms Ireland on 13 conditions; self-harm, pancreatic cancer, diabetes, brain cancer, prostate cancer, ischaemic heart disease, colorectal cancer, road injury, stomach cancer, congenital abnormalities, oesophageal cancer, falls and chronic kidney disease. Ireland outperforms the UK for 14 conditions; strokes, lung cancer, respiratory infections, chronic obstructive pulmonary disease (COPD), pre-term birth complications, other cardiovascular/circulatory conditions, cirrhosis, oesophageal cancer, aortic aneurysms, non-Hodgkin lymphoma, ovarian cancer, Alzheimer's disease, bladder cancer and kidney cancers. Particularly striking is breast cancer, a high-profile condition on which the UK ranks near-last among the 19 nations. Germany performs best among the four nations for chronic obstructive pulmonary disease, breast cancer, congenital anomalies, prostate cancer, aortic aneurysms, brain cancer and Alzheimer's disease. The Netherlands performs best of the four for ischaemic heart disease, road injury, preterm birth complications, cirrhosis and falls. Both performed better than Ireland and the UK for the treatment of strokes, lower respiratory

infections, oesophageal cancer, non-Hodgkin lymphoma and ovarian cancer and there were overall 16 conditions on which Years of Life Lost were lowest in at least one of the two continental nations (Germany and the Netherlands), compared to 11 where the same was true of the UK or the Republic of Ireland.<sup>123</sup>

Mortality Amenable to Healthcare (Sources: OECD & The Commonwealth Fund)	UK	Ireland	Netherlands	Germany	Average
Amenable Mortality, OECD, deaths per 100,000 in 2007 (Nolte & McKee), 31 nations	86 (19 <sup>th</sup> )	82 (17 <sup>th</sup> )	68 (6 <sup>th</sup> )	81 (16 <sup>th</sup> )	95
Amenable Mortality, OECD, deaths per 100,000 in 2007 (Tobias & Yeh), 31 nations	102 (20 <sup>th</sup> )	95 (18 <sup>th</sup> )	82 (9 <sup>th</sup> )	88 (16 <sup>th</sup> )	104
Amenable Mortality, deaths per 100,000 in 2007 (Nolte & McKee definition, Commonwealth Fund), 16 nations	83 (15 <sup>th</sup> )	78 (12 <sup>th</sup> )	66 (7 <sup>th</sup> )	76 (10 <sup>th</sup> )	70.9

Figure 5: OECD and Commonwealth Fund amenable mortality data in the UK and Ireland. OECD/16-nation averages and German and Dutch figures given for comparison (Sources: ‘Mortality Amenable to Health Care in 31 OECD Countries’ and ‘Variations in Amenable Mortality—Trends in 16 High-Income Nations’)<sup>124125</sup>

Most clear, perhaps, are the differences in performance on mortality amenable to healthcare. Former Civitas Health Unit director James Gubb described this statistic thus: “Avoidable mortality is based on the concept that deaths from certain conditions should not occur in the presence of timely and effective health care. Generally speaking, causes of death are included in this measure if they are either amenable to treatment and medical care and/or amenable to secondary prevention through early detection. For all, with the best health care, it is reasonable *to expect death to be averted even after the condition has developed.*”<sup>126</sup> This to some extent severs the specific performance of the health system from general background and public health factors, which can skew more general indicators, making it a somewhat better measure of the comparative effectiveness of health systems than infant mortality, PYLL or life expectancy. Here, it is first of all clear that although both Ireland and the UK were somewhat better than the average among 31 OECD nations, both are worse than the overall average when the sample was the more focused group of 16 high-income nations put together for the Commonwealth Fund (excluding several less comparable OECD members in Eastern Europe and Latin America). Second, Ireland in turn trails both Germany and the Netherlands, especially the latter. Third, among 31 OECD nations, the UK is 19<sup>th</sup> or 20<sup>th</sup> for amenable mortality while Ireland is 17<sup>th</sup>/18<sup>th</sup> and among the 16 high-income nations the UK ranks 15<sup>th</sup> (ahead of only the deeply flawed US system) and Ireland is 12<sup>th</sup> – this suggests that there is a close similarity between the performance of the UK and Irish systems.

### EHCI Rankings

Ireland’s performance is relatively weak in the Euro Health Consumer Index (EHCI), a ranking compiled by the Swedish-based company Health Consumer Powerhouse (HCP) that HCP feels “takes a consumer and patient perspective” and “offers reality checks for policy makers, empowerment to patients and consumers and an opportunity for stakeholders to highlight weak and strong aspects of healthcare”.<sup>127</sup> The 2009 Fine Gael document that outlined their Dutch-inspired healthcare reforms noted the following:

“Fine Gael has looked in some detail at the Dutch model. The 2008 Euro Health Consumer Index (EHCI) report suggests that the Netherlands is the most successful health system in Europe. It is number 1 for quality, ahead of Denmark. Ireland is only number 15. While per capita spending in the Netherlands is slightly ahead of Ireland (Figure 3), the EHCI’s analysis of value-for-money

suggests that the Netherlands produces a much bigger “bang for its health buck” than Ireland and most other European countries. The Netherlands is in second place for value for money, while Ireland is ranked an abysmal 24<sup>th</sup><sup>128</sup>

In that same 2008 study, the UK was thirteenth and Germany sixth. In 2009, Ireland came thirteenth, the UK fourteenth, while the Netherlands and Germany were again first and sixth, respectively.<sup>129</sup> When discussing waiting times, the EHCI authors also commented that “It is difficult to avoid the observation that for countries which do have official waiting time statistics (Ireland, Sweden, UK etc), this is in itself a not very flattering circumstance. Countries such as Germany, where waiting times tend to vary in the 2 – 3 weeks range, have never felt the urge to produce waiting time data, for principally the same type of reason that Madrid has [fewer] snow-ploughs than Helsinki.”<sup>130</sup> In the 2012 study, the Netherlands was again first, the UK twelfth and Ireland thirteenth. The report authors noted that “Countries who are known to have quite similar healthcare systems should be expected not to end up far apart in the ranking. This is confirmed by finding the Nordic countries in a fairly tight cluster [and] Ireland and the UK clinging together”, an assertion arguably consistent with the similar performance of the two systems on mortality amenable to healthcare.<sup>131</sup> In the 2013 edition released on November 28<sup>th</sup> 2013, the UK was in 13<sup>th</sup> place and Ireland was 14<sup>th</sup> (continuing the “clinging together” observation), with the Netherlands again first and Germany seventh.<sup>132</sup>

## Conclusions

Overall, international standing, health outcomes, accountability, equitable access, underfunding, rationing and waiting times are all clear problems in the current Irish system. In October 2013 a former doctor and Independent elected member of the Irish Seanad (Senate), John Crown, declared Ireland’s health system “the sick man of Europe” and argued in the Irish *Independent* that the system needed more medical professionals and fundamental reform based on universal social insurance, competition and diverse, mostly non-profit provision:

“Friends I have a dream today. I have a dream of an Irish health service where every woman, every man and every child could see the same doctor in the same hospital or clinic following the same reasonable wait if they have the same illness, regardless of their financial circumstances. The reality today is that we have a service where 40 per cent have “okay” care delivered in a timely fashion and 60 per cent have care that is mediocre at best and always tardy...I have a dream of a health system where every working citizen pays the same percentage of their income for the same health insurance benefits, where as a result the rich subsidise the poor, and where the unwaged are looked after by a caring society...I have a dream where a system of mostly not-for-profit insurance companies compete with one another and with the for-profit sector for the loyalty and custom of their members, using the weapons of service and efficiency – not the bondsmen’s whips of compulsion and administrative diktat...I have a dream of a republic which has the same number of doctors per head of population as other modern European social democracies, not one where a handful of oppressive bureaucrats in cahoots with rapidly rotating gormless politicians insist that we should be forever at the bottom of the league table for every speciality in medicine...I have a dream of a network of mostly not-for-profit hospitals and clinics, owned by a rainbow of charities, voluntary organisations, universities and municipalities, institutions which are obliged and incentivised to accept every citizen who presents to their doors needing care regardless of their financial circumstances...I have a dream of a diverse medical profession where doctors have rational, locally negotiated contracts that reflect diverse working circumstances, needs and environments; where they are allowed to do research if they wish, where they may set up in independent practice if they wish, but where all MUST accept the insurance of any citizen regardless of class, race or wealth, and one where they must care for all in the same facility with the same waiting time and with the same personal commitment to their health...I have a dream of a

medical education system which matches the number of doctors to the needs of society, where it is acknowledged that interns, senior house officers, registrars and specialist registrars are all trainees, whose positions exist to provide education not to extract a service.”<sup>133</sup>

## Universal Health Insurance (UHI): A New Beginning?

Due to these various problems, fundamental reform of the healthcare system became a subject of discussion prior to the last Irish election, held on February 25<sup>th</sup> 2011. Criticising the handling of the health service by the ruling coalition, Ireland’s main opposition centre-right Fine Gael (FG) party and the centre-left Labour Party (Ireland’s traditional third party) both brought out plans promising to bring about some form of ‘Universal Health Insurance’ (UHI, also known as Social Health Insurance or SHI). In the election, the incumbent government was defeated. The impact of the 2008 financial crisis and EU/IMF-mandated austerity measures were of course a dominant theme of the 2011 election, but healthcare reform was also an issue and was noted by commentators as a key point of confrontation in leaders’ debates in the final weeks of the election.<sup>134135</sup> The results led to the formation of a coalition government led by Fine Gael, with Labour as a junior partner, and the announcement of a new joint Programme for Government containing a clear UHI proposal based on the two parties’ previous plans.

### Fine Gael – “FairCare”

Fine Gael first outlined their UHI policy in a 2009 document (“FairCare”) while still in opposition, based on the findings of a commission they established in 2008.<sup>136</sup> In its foreword, FG leader Enda Kenney argued for an approach “built around the patient, rewarding performance from doctors and hospitals, and ensuring that there will no longer be a two tier health system”. He noted the Dutch health system as the inspiration for the proposed reforms, arguing that “The Netherlands spends only slightly more than us on health on a per capita basis, but has minimal waiting lists and is ranked number 1 in Europe for health.” He pledged that Ireland “will move towards the Dutch system, where everyone has mandatory health insurance, either subsidised or fully financed by the State”, but also that stakeholder consultation and consensus-based implementation would be key, in order that the Dutch model be “best adapted to Irish circumstances”. Kenney also stated that the recession and budgetary pressures at the time, cited by some as a barrier to reform, instead made radical reform a fiscal imperative in his view – Dr Sean Faughnan, the chief architect of the FairCare reforms, has similarly argued that the fiscal crisis is making reform both possible and necessary (“if not now, when?”), as little reform was achieved in the more prosperous era before the crisis due to a lack of urgency. FG argued it may be possible to establish a radically different and more effective system and remove wasteful spending. This may bring about up to €4 billion in savings by the end of the 2015.<sup>137</sup> These circumstances raise observable parallels with current debate over the NHS - in July, it was noted at a Nuffield Trust-RSA debate that the “storm” of the financial crisis has fundamentally changed the fiscal landscape of British healthcare, creating the need for the NHS to reform itself and do in times of austerity what it missed a chance to do in times of plenty.<sup>138</sup> Dr James Reilly, now the Minister of Health and a former GP and president of the Irish Medical Organisation, also attacked waiting times and argued that FG’s plans “will slash waiting lists, for a fraction of the money spent on the NTPF every year.” He also pledged a “money-follows-the-patient” funding formula designed to induce competition and reforms to primary care, involving “new primary care centres where groups of GPs with other healthcare professionals will treat patients free out of modern purpose built premises with access to x-ray, ultrasound and endoscopy so that patients can be diagnosed in their communities by the doctors who know them best”.

Implementing the Dutch model, in contrast to the centrally-run and tax-financed HSE and British NHS models, essentially means guaranteeing universal healthcare access by mandating that all residents obtain health insurance covering a state-mandated package of benefits from competing insurers. It is these insurers that finance healthcare on behalf of their members, paying separate healthcare providers within a purchaser-provider split system. The Dutch government increasingly plays a role in providing consumer information to its citizens to guide their choices with regard to insurers and providers. Over 90% of Dutch hospitals are privately run, although on a non-profit basis (in the Netherlands, it is illegal for hospitals to be for-profit) and primary care is gatekeeper-based. Out of pocket payment for core-package treatments, including primary care, has historically been very minimal and the insurance premiums of many residents must be subsidised in whole or in part from general taxation on a sliding scale based on income, in order to ensure that insurance coverage is accessible to all. As a result, 85% of healthcare financing in the Netherlands comes from public funds, compared to 83% in the UK and 67% in Ireland – out of pocket health spending is even lower than in the UK.<sup>139</sup> By law, citizens must buy insurance or face a fine. The strict enforcement of community rating and an obligation to cover are also key to this system – the government aims to ensure that insurance companies will not discriminate against people based on age, sex, medical history or so on. Risk equalisation, wherein insurers covering higher-risk patients receive redistributive government-enforced payments from insurers carrying lower risk, is also key. The Irish government has already introduced these last two measures in order to try to fairly regulate the existing voluntary health insurance market (see ‘Current Financing Model - Private Health Insurance’ above), but thorough enforcement of them will be all the more important in a Dutch-style UHI system in which universal health insurance is essentially the basis of all healthcare access. The Dutch system was also found to be the best of seven healthcare systems examined by the US-based Commonwealth Fund in 2010, as at the time it was found best able to combine quality, equity and accessibility.<sup>140</sup> Overall, the government enforces universality, sets standards, provides most funding and regulates competition, while allowing diverse insurers and providers to run the system day-to-day. Though the Netherlands has had a social insurance healthcare system since the 1940s, previous flaws in the system led to an overhaul and a shift to the current privatised managed-competition version of this system in 2006 – Civitas has a detailed report on the Dutch system and these reforms, available [here](#). Dr Sean Faughnan has however stressed that since the Irish government’s intent is to shape the system to Irish needs, Ireland’s reforms should not be judged on their similarity to the Dutch model per se, but on whether they work.<sup>141</sup>

Fine Gael examined other systems, including the German health system, but the “FairCare” document outlines a clear rationale for why FG favoured the Dutch system over other potential healthcare models. It explains that there are “basically three different models of healthcare right now”; Beveridgean (with a “centralised monopoly health service provider financed from taxation: Ireland, UK”), “Business” (“voluntary private insurance: USA”) and Bismarckian (“mandatory social insurance with tax subsidies; decentralized and independent health service providers: Germany, France, the Netherlands”). Citing evidence by the British pro-market think-tank Reform, the document argues that the insurance-based Bismarckian model is superior because they “achieve greater value”, “help de-politicise healthcare”, “provide reasons for individuals and authorities to value long term improvements in health and wellbeing” and “define exactly what individuals are covered for, ending postcode lottery and empowering individuals to demand their rights from providers” – these are all benefits of continental-style social health insurance models that Civitas has similarly noted in the past.<sup>142</sup> The fact that UHI

could be built out of Ireland's present voluntary insurance system, allowing Ireland to incrementally develop a mandatory insurance system that will "level up the playing field, not level it down" and reduce the duplicate administration costs of having both private insurance and a large public HSE was also cited as an attraction. This argument is valid in Ireland's case, though it may not apply as straightforwardly to Britain at the current time, given our less developed voluntary insurance market. The FG document notes the Dutch system's first place ranking in the Euro Health Consumer Index (see 'Current Problems: The Case for Reform - EHCI Rankings' above) and expressed an aspiration to make Ireland a "top three" system like the Netherlands within two terms of government. The FG document also stresses that access to healthcare will be "a right - not a privilege" in the new system and makes clear the difference between the Dutch model and the deeply flawed and voluntary insurance-based "Business model" of healthcare in the US:

"Under the Dutch system, **which is totally different from the inefficient and inequitable US private health insurance model**, everyone must buy a standard healthcare package from one of a number of competing insurance companies. This package covers all of the services and treatments one would normally expect – GP and hospital care, medicines, maternity care, ambulances, etc. In addition, anyone can buy supplemental packages, which include cover for additional, non-essential medical treatments (cosmetic, dental, therapies, etc.). The insurance companies, in turn, purchase services from the healthcare providers (hospitals, etc.) and cannot turn any customer down, regardless of their health history. Community rating and risk equalisation ensure that no patients are discriminated against when premiums are being set. GPs, rather than insurance companies, decide on treatment, while the quality of the health system is guaranteed by the State, which still pays for around three-quarters of healthcare costs through taxes. It also pays the premiums of children and those with medical cards and subsidises the premiums of the less well off"

HSE hospitals would continue to be state-owned, but "will be governed and managed by Local Hospital Trusts" rather than by the HSE. Voluntary hospitals would stay under their current board ownership, as "The evidence from other countries is that these independent, not-for-profit hospitals tend to do best under systems of universal health insurance", potentially because "the caring ethos of not-for-profit hospitals leads to higher quality treatment and greater trust among patients and their insurance companies".

### *Proposed Implementation Process*

The 2009 document went on elaborate that the plan would be implemented in three phases. In the first year, a Special Delivery Unit to combat waiting times would be established, based on a similar initiative in Northern Ireland (achieved in June 2011), and more care in the community would be encouraged – these were essentially cost-efficiency initiatives within the existing HSE system. The second phase, to begin in the third year of the five-year plan, was the introduction of "money follows the patient" in the hospital system. The third phase, intended to be delivered sometime after year five, was the introduction of free GP care, universal insurance and "choice for all". It pledged the creation of a "UHI commission", featuring major stakeholders in the system, to ascertain how the proposed reforms could best be implemented. Though UHI "will require the insurance industry in Ireland to play a much greater role in negotiating contracts with hospitals and other providers, and in driving innovation", the FG plan pledged that they would "not introduce UHI until it is certain that the insurance companies are capable of taking on the expanded role required of them".<sup>143</sup>



An additional document released in 2011, closer to the election as a key plank of Fine Gael's 5-point plan for Ireland, included more implementation details.<sup>144</sup> This clarified that UHI would be delivered by 2020, with the third phase of implementation taking place between 2016 and 2020. Phase 1 (2011-2014) was to reform the existing HSE system, phase 2 (2014-2015) was to change how hospitals work. This document also clarified that Medical Card holders would continue to have free GP care and that "free GP care will be extended to everyone else in a second term of Fine Gael Government as the country's finances improve".<sup>145</sup> The 2011 document also stated that "As part of our UHI reforms, a Fine Gael government will maintain the VHI in state control as a 'public option' for customers. However, we believe it should be slimmed down considerably so that it no longer has a dominant market position" – this was due to a belief that VHI had not used its dominant, quasi-single-payer role within the Irish voluntary insurance market to set prices effectively.<sup>146</sup> The phrase "public option" entered usage in the 2009 healthcare reform debates in the US, referring to an opt-in government-owned insurance organisation competing against private insurers within a multi-payer market, intended to prevent the emergence of private monopolies, hold down costs and ensure affordable access for groups that could be affected by any covert risk-selection practices on the part of for-profit insurers (though it was not included in the final US Affordable Care Act legislation, so the Irish example of it will be particularly interesting to watch).<sup>147</sup>

## Labour – UHI

The Irish Labour Party first called for a new system based on universal health insurance and competing providers in 2001 in a document called "Our Good Health".<sup>148</sup> Before the 2011 elections, Labour released its updated plans for UHI and "fair health care", stressing five key points:<sup>149</sup>

1. "Universal primary care insurance instead of the medical card system and payment out of pocket"
2. "Universal hospital care insurance instead of the two-tier system of private and public patients"
3. "Public and private hospital care insurers who purchase hospital care for you from competing public and private hospitals and clinics"
4. "A new public insurer created by combining the National Treatment Purchasing Fund and the purchasing arm of the HSE, both of which currently fund public patient care"
5. "The right to change insurer"

A core aim of the plan was to equalise access to primary care, "end the two-tier system in hospital care" and make "the hospital system more efficient" – Labour stressed that these plans were "costed, planned and timetabled". Labour elaborated that:

"everyone will have a choice of insurer - public or private. Insurers will purchase care from hospitals, which will compete to supply care. HSE-owned hospitals will become independent, not-for-profit foundations or trusts...The National Treatment Purchase Fund and the purchasing arm of the HSE will combine to become a Hospital Care Purchase Agency that purchases care for the uninsured during the preparation for the full system. In 2016, this agency will become a new public insurer. As in Germany, there will be multiple insurers of hospital care but centralised control of costs and fees. Irish health care will continue to be funded by a combination of Exchequer resources and insurance. People on lower incomes will have their insurance premia

paid by the state; people on middle incomes will have their insurance payments subsidised; and people on higher incomes will continue to pay their premia...A guaranteed basket of care, which every insurer will be required to offer, will cover consultant-provided hospital care and semi-private accommodation in hospitals - public or private. Yet, unlike the current unfair system, under Universal Health Insurance, anyone who can no longer afford a premium due to loss of a job or a fall in income will no longer lose their hospital care cover”<sup>150</sup>

The full Labour document explained that “Under universal health insurance, when you are in work and earning a good income, you will contribute to the system. If you are out of work or on a low income, if you are ill and cannot work, even though you cannot contribute to the system, you and your children will have the same access as everyone else” and argued that given Ireland’s economic and fiscal crises, “we need social solidarity more than ever. Reform is no longer just an aspiration for Irish health care - it is now an essential”.

The health system model proposed by Labour is notable for its striking similarities to Bismarckian health systems on the continent and its lack of similarity to the British NHS model - there is a direct reference to Germany’s model and an intention for there to be a nominal form of competition between both public and private insurers to provide a guaranteed package of care. Labour’s original 2001 UHI document also described the UK National Health Service model as “one of the most chaotic” health system models and noted that “in most advanced countries there is a mix of state and private funding and provision”, while simultaneously attacking the inequitable, non-universal US model as “one of the most expensive”.<sup>151</sup> A 2008 party policy document noted that “Ireland has only half the number of GPs per head of population as Germany and one third that of France”, again showing Irish Labour’s preference for the continent as an inspiration.<sup>152</sup> On the provision side, Labour’s 2011 plan clearly proposed to convert HSE hospitals into non-profit trusts or foundations, potentially comparable to either recent UK government policy on foundation hospitals or perhaps even to a 2003 Civitas idea to convert British NHS hospitals into non-profit trusts, depending on the exact legal details of Labour’s idea.<sup>153</sup> However, Labour is still unambiguously critical of the current Irish system’s reliance on charges (“fees and charges are barriers to accessing care in need”), means-testing (“there is always a denial of access to people who are above the threshold for state support and not rich enough to pay fees”) and voluntary insurance (“private health insurance lapses if you cannot pay your premium”), stressing that Labour “believes in universalism”.

While there are “distinct differences in the detail of each party’s approach”, as Trinity College Dublin health lecturer Dr Fergus O’Ferrall noted, there are common features in the Labour and Fine Gael approaches to UHI, despite the fundamental ideological differences between these two parties.<sup>154</sup> The main difference was a disagreement over the nature of competition and the role of the ‘public option’ both pledged to include in the multi-payer system. In the final Irish leaders’ debate, Labour leader Eamonn Gilmore stated Labour was in “broad agreement with Fine Gael” on UHI, but would not abolish the HSE entirely as to do so would involve too much restructuring, a reference to the promise to fashion the National Treatment Purchasing Fund and HSE purchasing arm into a public insurer (the “Hospital Care Purchase Agency”) to compete with the private insurers.<sup>155</sup> Labour would also have retained the VHI as a public-owned insurer, with the intention that both these public insurers would compete with private insurers – Labour noted that in the Irish electricity market, two publicly-owned providers compete with various private providers to prevent monopolies.<sup>156</sup> Fine Gael’s plan, by contrast, was designed on the basis that a state role in the market on this scale could amount to a quasi-single-payer system and “crowd out private health insurance companies” by dominating “up to 80%” of the

insurance market, instead promising to clearly abolish the HSE while retaining the VHI as a “slimmed down” publicly-owned insurance option as stated above.<sup>157</sup> Both, however, implicitly recognised the benefit of some sort of public option in the market to counter private monopolies, control costs and protect consumers.<sup>158159</sup> Labour’s 2001 health document had suggested the VHI would be “separated from government ownership by the formation of a statutory trust (or another suitable arrangement), but it will not be privatised”.<sup>160</sup> In the UK, plans put forward for a hypothetical social insurance system by Norwich Union Healthcare<sup>161</sup> and Liberal Democrat MP David Laws<sup>162163</sup> each suggested that the public NHS should be retained as a large membership-based insurer competing with private or non-profit insurers to provide a set treatment package, along the lines of role envisioned for Irish Labour’s hypothetical public Hospital Care Purchase Agency.

The German universal Social Health Insurance (SHI) health system, cited by Labour, is often acknowledged to be world-class and was a point of discussion in the recent German election in September 2013. Germany’s health system was founded in 1883 by Otto von Bismarck, hence why the social insurance-based systems used in the Netherlands and much of the rest of continental Europe it inspired are described as “Bismarckian” systems. This system is universal and funded primarily from payroll contributions, supplemented by general revenue. The role of direct National Insurance-style contributions means a contributory principle is upheld, something some UK politicians are exploring how to resurrect and Labour MP Frank Field recommended for the NHS in a September 2013 publication for the think-tank Politeia.<sup>164165</sup> German universal healthcare also incorporates public, private and civil society sector elements. 85% of Germans are covered by public health insurance (GKV), which in Germany’s case includes 140 smaller non-profit *krankenkassen* (sickness funds). Those earning over €52,200 can instead buy private insurance (PKV) from competing private insurers. Hospital capacity is divided between municipally-run public hospitals, religious or guild-affiliated non-profit hospitals and smaller for-profit hospitals. Outcomes, spending, numbers of doctors and beds and technological access are better than in the UK and waiting times are the lowest in the OECD.<sup>166167</sup> Reforms in 2007 and 2010 created a €26bn surplus in Germany’s system and in December 2012, the Bundestag was able to vote to abolish a €10 per quarter fee introduced on GP visits in 2004, restoring free at the point of use GP care for Germans.<sup>168</sup> The main drawback to the German system is that German employers contribute directly to funding, which some feel places an anti-competitive burden on the German economy. However, the Irish Labour proposal appeared to rely on Dutch-style individual direct subsidised premiums (“Depending on our income, we will either pay a premium directly to this insurer or the Hospital Insurance Fund will pay the insurer for us or subsidise our payment”), likely bypassing these problems.<sup>169</sup> Choosing insurer in Labour’s original proposed system also appeared more straightforward than in the complex income-restricted GKV/PKV split in Germany, with all Irish residents having a choice between two public insurers and perhaps several private insurers. Civitas has a detailed report on the German system, available [here](#).

Irish Labour policy is interesting from a British political standpoint, demonstrating that the centre-left’s essential commitment to the principles of solidarity and universalism in healthcare can be consistent with support for provider diversity, social health insurance and relative scepticism towards centralised administration. Irish Labour also has somewhat close ties with its UK sister – Irish and UK Labour MEPs sit together in the Progressive Alliance of Socialists and Democrats (S&D) political grouping in the European Parliament and in October 2012, Eamon Gilmore and Irish Labour hosted senior UK Labour parliamentarians Ed Balls, Peter Mandelson and Rachel Reeves in Dublin for the international Progressive Governance Conference.<sup>170</sup>

Further, the health systems on the continent inspiring the Labour plans often boast strong historical support from their local S&D parties, notably from the Social Democratic Party in the case of Germany. It could be of benefit to the UK if our domestic Labour Party could learn from its counterparts and explore competition, decentralisation and social insurance as options for the delivery of universal healthcare.

### *Proposed Implementation Process*

Labour outlined a six year implementation process in their reform plans. Primary care reform would take four years, culminating in the establishment of free at the point of use care following the extension of medical card access, the establishment of a Primary Care Insurance Fund and the seeking of EU permission for the new system. Hospital care reform would take six years. Within two years, the National Treatment Purchase Fund would be used to purchase diagnostics for those unable to afford them, a public insurer would be developed, the Department of Health would prepare a cost-effective pricing and funding guide for care to be covered under UHI and public hospitals would prepare to become independent from the HSE. In year three, the NTPF would have merged with the purchasing arm of HSE to become a single public purchaser and a detailed Universal Hospital Care Insurance Bill would be published (to be passed in the fourth year). In year four, hospitals would gain foundation status and begin to compete to provide care to the new public “Hospital Care Purchase Agency” and private insurers and in year five, a “Hospital Insurance Fund” would have been established. In year six, the full universal system with choice of insurers would come into force. The timetable for the implementation of free primary care was noticeably more truncated than in Fine Gael’s proposal.

### **Programme for Government**

The coalition Programme for Government released on March 5<sup>th</sup> 2011, written following negotiations between FG and Labour, included seven pages devoted to healthcare, including a pledge to “introduce Universal Health Insurance with equal access to care for all. Under this system there will be no discrimination between patients on the grounds of income or insurance status. The two-tier system of unequal access to hospital care will end.”<sup>171</sup> The outline contains elements from both parties’ largely comparable pre-election plans, but also reflects compromises made between the two – these were mainly to do with the implementation timetable for free GP care. The final version also firmly agrees that the HSE will be abolished and not retained as a Hospital Care Purchasing Agency insurer as Labour had proposed, though the VHI will remain as a ‘public option’.<sup>172</sup>

- “As a statutory system of health insurance, guaranteed by the State, the Universal Health Insurance system will not be subject to European or national competition law”
- Risk equalisation would be introduced
- A Special Delivery Unit will be established to reduce waits
- “A Patient Safety Authority will be established”
- “The Health Service Executive will cease to exist over time. Its functions will return to the Minister for Health and the Department of Health and Children; or be taken over by the Universal Health Insurance system”

#### **Primary Care**

- “Universal Primary Care will remove fees for GP care and will be introduced within this Government’s term of office. The legislative basis for Universal Primary Care will be

established under a Universal Primary Care Act. Universal Primary Care will be introduced in phases“

### **Hospital Insurance**

- “A system of Universal Health Insurance (UHI) will be introduced by 2016, with the legislative and organisational groundwork for the system complete within this Government’s term of office. UHI will provide guaranteed access to care for all in public and private hospitals on the same basis as the privately-insured have now. Insurance with a public or private insurer will be compulsory with insurance payments related to ability to pay. The State will pay insurance premia for people on low incomes and subsidise premia for people on middle incomes. Everyone will have a choice between competing insurers”
- “The VHI will be kept in public ownership to retain a public option in the UHI system”
- “Exchequer funding for hospital care will go into a Hospital Insurance Fund which will subsidise or pay insurance premia for those who qualify for subsidy. The Hospital Insurance Fund will oversee a strong and reformed system of community rating and risk equalisation [and] provide direct payments to hospitals for services that are not covered by insurance such as Emergency Departments and ambulances”
- “Under UHI insurers will be obliged to offer the same package of services to all. This guaranteed UHI package will be determined by the Minister for Health in consultation with the Hospital Insurance Fund and medical experts and will be regularly reviewed...Insurers will not be allowed to sell insurance giving faster access to procedures covered by the UHI package”
- “In the first term of this Government, the foundations will be laid for the introduction of Universal Hospital Care Insurance: The legislative basis for UHI will be enacted...The HSE’s function of purchasing care for uninsured patients will be given to a Hospital Care Purchase Agency which will combine with the National Treatment Purchase Fund to purchase care for the uninsured over this transition period. This separation of purchaser-provider functions will enable the development of a money follows the patient system of purchase of care for people without insurance before the implementation of the UHI system”

### **Providers**

- “Under UHI public hospitals will no longer be managed by the HSE. They will be independent, not-for-profit trusts with managers accountable to their boards. Boards will include representatives of local communities and staff”
- “Hospitals will be paid according to the care they deliver and will be incentivised to deliver more care in a “money follows the patient” system. Insurers will negotiate directly with hospitals to help control costs and encourage innovation in the delivery of care”
- “Insurers will not take over the running of hospitals which will be independent providers of care separate from insurers as purchasers of care”
- “The Hospital Insurance Fund will assist hospitals in more remote locations that may not have a large throughput of patients to continue to provide important local services”

## **UHI: Criticisms, Implementation and Challenges**

UHI does have its critics, however. Further, there have been issues in the initial years of implementation (though alongside early successes). Both of these things are of course to be

fully expected in a wide-ranging process of reform like UHI, but nevertheless, it is important to make note of the issues raised with UHI in order to learn from them.

### Criticisms of UHI

The Minister of Health in the previous Fianna Fáil-led government Mary Harney criticised the idea of UHI in 2010, claiming the initiative “did not promise a one-tier system for all” and stating that “What matters most is how resources are used, not how resources are raised from the public,” she said. Harney did make a somewhat valid point that a “pure one-tier system is not on offer, from anyone that I can see”, in the sense that “Both Social Health Insurance and Compulsory Private Health Insurance recognise that people will still be free to purchase additional private health insurance, and go to doctors and hospitals privately, above and beyond the State benefits package” – there is indeed perhaps a slight oversimplification in ever attempting to promise to fully “one-tier” system of healthcare.<sup>173</sup> Nevertheless, this critique ignores the lack of a guaranteed healthcare package and a clear, equal right to access under the existing Irish system and the clear pledge the current government have made to ban duplicative cover for faster access under their plans for UHI. In the Netherlands, it has also been the case that around 90% take out voluntary supplementary insurance to cover non-package treatments, so access to this can become fairly broad, if not quite universal.<sup>174</sup> Israel, a similar Universal/Social Health Insurance system where voluntary supplementary cover is commonplace but not universal (80% of the population), has also demonstrated how government oversight can to some extent limit inequities. In 2008 when several new life-saving drugs not included in the Israeli public national benefits package were becoming accessible only to those with special supplementary insurance, the Israeli government responded to a rightful outcry by adding funding for the drugs within the national benefits package and banning supplementary insurers from covering them.<sup>175</sup> Harney also argued that the FG ‘FairCare’ plan outlined in 2009 included a €1 billion funding gap in primary care, though James Reilly countered that this estimate did not take account of intended incentives for GPs to establish “one stop shop” clinics with “physiotherapists, occupational therapists, GPs and other staff” (perhaps similar to UK polyclinics) that would yield savings.<sup>176</sup>

In October 2013, the Fianna Fáil opposition released a report they commissioned by Dr Brian Turner, an economist at University College Cork, which they explained had found that “there is simply insufficient evidence from international systems to suggest that a change in the funding mechanism along the lines planned by the Government would produce benefits sufficient to justify the disruption that such a change would cause”. Specifically, they criticised the Dutch model for its expense and noted problems in the existing Irish insurance market with cost-inflation, risk pooling and insufficient government subsidies.<sup>177</sup><sup>178</sup> Turner also argued that a multi-payer system might have less strategic direction and that the presence of for-profit insurers could mean some funds being directed towards profits rather than provision. However, Turner’s report did note the inequity of the current Irish system and the need for reform. Further, he ceded that “One of the disadvantages of the current taxation-funded system in Ireland is that it is not as transparent as some other funding mechanisms would be”, and while he suggested hypothecated taxation as a solution, within a single-payer system users still cannot direct their hypothecated contribution and induce competition by switching insurers.<sup>179</sup> Turner’s understandable concerns about cost inflation and about funds being diverted into insurer profits may be in part remedied by the continued presence of the non-profit VHI among the insurance options. A further possible remedy, currently being implemented within Barack Obama’s mandatory insurance-based Affordable Care Act reforms in the US, could be for the government

to proactively encourage the founding of non-profit private cooperative insurers to compete with established for-profit firms. This could bring about a social insurance system consistent with Senator John Crown's vision of "a system [where] mostly not-for-profit insurance companies compete with one another and with the for-profit sector for the loyalty and custom of their members".<sup>180181</sup>

In 2010, a health charity called the Adelaide Hospital Society did publish a report entitled 'Effective Foundations for the Financing and Organisation of Social Health Insurance in Ireland', in which they appeared to offer support to a single-payer version of UHI (without insurer competition), or to at least warn that within a multi-payer version of UHI a smaller number of large competing insurance funds might be preferable, as "larger sickness funds operate more efficiently, both in being able to hold reserves, benefit from economies of scale in administration and have larger risk pools". They argued that a single national Social Health Insurance fund run by a not-for-profit private organization would avoid the complexities associated with insurer competition and could still "reflect its membership in some ways either through direct elections or nominations by relevant representative bodies".<sup>182</sup> Labour MP Frank Field's September 2013 proposal for the UK to fund healthcare from a form of 'John Lewis-style' mutualised, single-payer social insurance, which would introduce a contributory principle to the NHS while retaining its free at the point of use principle, arguably mirrors the Adelaide proposal.<sup>183</sup> Again, however, a single-payer model might not yield the benefits insurer competition may bring for users in terms of choice and direct accountability.

In January 2013, Professor Ilaria Mosca of Erasmus University Rotterdam argued that "A quick scan of the 2006 [Dutch health] reform, seven years after its implementation, shows significant improvements in the accessibility of health care services and the availability of health (quality) information", certainly a positive outcome, but she also added that the Dutch reforms had been "less successful on other fronts such as cost containment and efficiency", demonstrating issues that will need to be tackled in the Irish version of the system.<sup>184</sup> In 2013 health economist Padhraig Ryan explored the potential of Dutch-style managed competition for Ireland, noting four issues to be addressed; Ireland's "relatively sparse hospital distribution" and its mixed implications for bargaining power in purchaser-provider negotiations, the need to develop a robust risk-equalisation mechanism (now achieved in Ireland, as of January 2013), the need to improve clinical performance measurement in Ireland (more advanced in the Netherlands at current) and the need to ascertain whether Ireland would benefit more from having many insurers (to prevent monopolies) or a smaller number of large insurers (with greater bargaining power on behalf of patients).<sup>185</sup>

### Implementation Process and Emerging Issues

Ireland is now almost three years into a potential five-year term in government (the next Irish election must be held no later than April 2016). While bearing in mind the scale and complexity of the overhaul now underway in Ireland and the possibility that there will be complications, it is informative to follow the process laid out for the reforms by the Irish government and what progress there has been so far.

In June 2011, the Northern Ireland-inspired Special Delivery Unit was established to tackle waiting times (see 'Current Irish Health System – Private Provision and the National Treatment Purchase Fund'). In July 2012 the Health Service Executive Governance Bill 2012 was proposed, which would formally abolish the entire HSE as of 2014, and HSE Chief Executive Cathal Magee

announced his intention to step down.<sup>186</sup> This bill was passed and enacted in July 2013 – an interim public Healthcare Commissioning Authority (HCA) will then act as a purchaser until private insurers take over at a later stage.<sup>187</sup> In February 2012, Minister of Health James Reilly set up a panel of experts from the HSE, major hospitals and universities to explore implementation for UHI.<sup>188</sup> In April 2012, Minister of State for Primary Care Roisin Shortall (Labour) announced the government were giving “approval to the preparation by the Department of Health of Heads of a Bill to progress the phased introduction of free GP care in line with the commitment in the Programme for Government”.<sup>189</sup> Risk equalisation was introduced in January 2013 (see ‘Current Financing - Private Health Insurance’ above).

In March 2013, the Department of Health released ‘The Path to Universal Healthcare: Preliminary Paper on Universal Health Insurance’, outlining six workstreams that were contributing to UHI implementation (primary care reform, hospital financing, hospital structures, regulation of the healthcare sector, the private insurance market and overarching UHI design).<sup>190</sup> The report provided updates on where implementation stood with each of the six streams. It also explained the units that had been set up to oversee reform, including the 12-person Implementation Group on Universal Health Insurance announced by James Reilly in February 2012, a Universal Primary Care Project Team, a Programme Management Office (PMO) for Health Reform with “a central, overarching, co-ordination function in relation to health reform” and a Health Insurance Consultative Forum including insurance industry representatives. Finally, the document also reviewed existing social insurance systems and their various arrangements. This discussed what the guaranteed ‘basket of services’ might involve and noted what was covered in other countries and how these determinations had been made. It made clear that “The establishment of a robust and transparent process for determining the standard basket of services will be central to the success and sustainability of the future UHI system in Ireland” and a set of underpinning values will be needed.<sup>191</sup> A detailed white paper, based on the March 2013 preliminary paper, will be released soon.<sup>192</sup>

In May 2013, James Reilly announced the reorganisation of Ireland’s public hospitals into six groups, described as “the most fundamental reform of the Irish acute hospital system in decades” – these reforms required great sensitivity and were regarded as a major achievement by the government. The idea of regional groups is to increase coordination, facilitate integration with community and primary care and to “maximise the amount of care delivered locally, whilst ensuring complex care is safely provided in larger hospitals”.<sup>193</sup> In August 2013 the government pledged to provide free GP care to under-5s, allocating €37 million for this purpose.<sup>194</sup> Legislation for this is currently being introduced and they aim to introduce it sometime in 2014.<sup>195</sup>

### *Emerging Issues*

Dr Sean Faughnan has identified funding (the need to balance necessary spending reductions with the ambitions of UHI) and the impact of the legislative process as two factors that may affect UHI implementation. However, he argues that stakeholders had begun to come on board and that reductions in waiting times represented an early success.<sup>196</sup>

Also pressing is the need to find a way to make Ireland’s long-term social care system (Fair Deal) work with the emerging UHI system. The HSE currently funds both health and social care, though there is a lack of structural integration on the ground, in terms of providers. Under the new system, health will be handled under UHI while long-term social care will continue to be



funded separately from general taxation, making integration a key issue. The government's 'The Path to Universal Healthcare' document discusses the earmarking of funds, the use of integrated contracts, bundled payment and IT as options for bringing about integration.<sup>197</sup>

Health spending and the need to deliver reforms on-budget has been identified as a politically contentious part of 2014 Irish budget by some commentators.<sup>198</sup>

Finally, a basket of covered services will need to be set, which will involve setting guiding principles and will need to "balance comprehensive, universal coverage with financial sustainability and financial constraints" and be based on clear healthcare goals – in November 2013, Professor Reinhard Busse of the European Observatory on Health Systems and Policies discussed the treatment packages and related decision-making processes of other countries as an example for Ireland<sup>199</sup> (Civitas has outlined the Dutch<sup>200</sup> and Swiss<sup>201</sup> benefit packages in profiles of these two systems). While setting a defined package will stamp out the ad hoc postcode lotteries the HSE currently has, like the UK Ireland has never had an explicit entitlement package of this kind and crafting it will require sensitivity. On the one hand, there is a risk that some people could lose existing services when a set package is defined, but on the other, the expense of extending effectively 'new' benefits to others could be high – this process will require careful and widespread consultation.

Oliver O'Connor, an independent healthcare consultant and former ministerial special advisor, noted that a key issue for the 2013 UHI white paper would be cost, as the initial March 2013 paper was unable to discuss costing options clearly. Nevertheless, he overall concluded that "With limitations, [the March 2013 paper] is a useful document", as while it did not make any new and clear decisions it did "illustrate the range of issues that have to be addressed to get to UHI" and drew on international literature. He concluded that the report demonstrated that Ireland was still "at Base Camp One, but the planning for ascending the peak is underway. Just how daunting the ascent may be is becoming clearer".<sup>202</sup> In November 2013 O'Connor wrote an article in the Irish *Independent*, arguing that UHI "won't happen as promised by 2016", that "big, bold steps have to be taken to make UHI real; not safe, incremental ones" and that transparency with the public was needed about costs – however, crucially, he also warned not to let "mere cynicism defeat ambition".<sup>203</sup>

Civitas researchers Claire Daley, James Gubb and Emily Clarke noted the following about the Dutch reform process, which Irish policymakers have studied closely and British policymakers would be well-served to take account of:

"even if the Netherlands' health care system cannot be used as an exact blueprint for Britain, the UK government would be wise to follow the methods of implementation used in the Netherlands to bring in the 2006 reforms. The Dutch were meticulous in their openness, ensuring that they kept the public informed throughout the reform process. Furthermore, the 2006 reforms were not the result of rushed ideas but rather the culmination of decades' worth of deliberation and discussion which helped to avoid later costly U-turns. Thus, if the UK is to follow NHS reform through successfully, the Government would be wise to learn from the 'particularly effective public information campaign' that was deemed to be 'a model of robustness and clarity' in the Netherlands and to bring reforms in gradually"<sup>204</sup>

## Conclusions: Lessons for the UK

### Close cousins, but some differences

Many of the existing issues in the Irish health system and its performance on some measures of healthcare quality are very comparable to those of the British NHS – this is unsurprising given the relative similarities between our nations and core systems. Though there are differences, the Euro Health Consumer Index (EHCI), the OECD, the European Parliament, academic researchers and Ireland’s Fine Gael party have grouped the UK and Ireland together as tax-financed ‘Beveridgean’ or ‘national health service’ systems with a “centralised monopoly health service provider financed from taxation” (FG definition) at the core of the health system.<sup>205</sup> As with the UK NHS, the Irish service has seen reorganisations, culminating in the creation of the current Health Service Executive (HSE) in 2005. The system also faces problems familiar to the UK in terms of waiting times, relative underfunding, centralisation and accountability, numbers of doctors, technological uptake and clinical outcomes – the performances of the UK and Ireland on mortality amenable to healthcare within the OECD and in consistent Euro Health Consumer Index (EHCI) rankings are in particular strikingly similar. In the background, population health in the UK and Ireland is also somewhat comparable in respects – for example, we are the two most obese nations in Europe. However, the somewhat mixed financing arrangements in the otherwise-similar and taxpayer-funded Irish system represent a difference and the larger role for voluntary insurance within their existing system provides an easier jumping-off point towards Universal Health Insurance, perhaps. Ireland’s non-profit voluntary hospitals, a sign of commitment to diverse provision and civil society within the taxpayer-funded public HSE, are also something that the UK has lacked since nationalisation in 1948 - finding a way to resurrect similar modes of health provision here would be beneficial to British civil society.

### Emerging case study of fundamental reform

Due to the plans now underway, Ireland is on the road to becoming a Bismarckian universal social health insurance (UHI/SHI) system, explicitly based on the Netherlands and comparable to Germany, Belgium, Israel, Switzerland, Luxembourg, Austria, France and Japan. Healthcare will be universal, collectively financed and there will be a state-mandated package of treatments that will be largely free at the point of use. This will be achieved within a ‘multi-payer’ social market model, where citizens will obtain an insurance package from either the government-owned insurer VHI (the ‘public option’) or one of several competing private insurers, with the government subsidising premiums for much of the population from general taxation - the overwhelming majority of healthcare funding will thus remain public, but people’s direct contributions to the system in the form of premiums will allow them to demand accountability and value for money. The government will also regulate the market heavily to ensure insurers provide the guaranteed package and treat all customers equally regardless of age and health. The insurers will purchase treatments on behalf of their customers from public voluntary or former HSE hospitals (which will become non-profit trusts or foundations) and from private hospitals – patients will have the right to choose to be treated in either, as opposed to the privileged access private insurance holders currently have to speedy private treatment in both Ireland and the UK. Supplementary insurance to cover health treatments not included in the state package may become separately available on the private market, but duplicative insurance to secure faster access to core treatments will be banned.

These proposals are closely in line with the main recommendations the Civitas Health Policy Consensus Group (HPCG) suggested for UK healthcare funding, which were also explicitly based on lessons learned from continental healthcare models:<sup>206</sup>

- “The primary role of government should be to create the legal and regulatory framework, to ensure that access to a high standard of care is guaranteed to all, and to ensure the supply of essential public health services”
- “Patients should have a choice among a range of competing healthcare providers”
- “Health insurance should be compulsory”
- “Patients should be free to choose from among a range of third party payers so that the allocation of resources follows from patient preferences”
- “There should be no compulsory user charges”
- “Politicians must not override the professional duty of clinicians to act in the interests of patients”

Comparable to the Irish government’s plans to convert HSE hospitals into independent non-profit trusts or foundations, the HPCG also recommended that all NHS hospitals could become independent foundation hospitals, “whilst ensuring that their assets must be permanently used to provide health care. Existing NHS hospitals should not be transferred to the ownership of for-profit institutions”.<sup>207</sup> Some proposals put forward for UHI in Ireland had common features with other social insurance proposals mooted in the UK, such as the 2003 proposal by David Laws MP for a ‘National Health Insurance Scheme’ and the recent proposal by Frank Field for a mutual NHS funded from social insurance.

However, Ireland’s decision to follow this reform path is nonetheless groundbreaking. In 2009, the Social Market Foundation commented on the possibility of a switch from tax-financing to social insurance for healthcare in the UK, stating the following: “There are strong arguments against the adoption of a social insurance scheme in the UK, even in the context of a severe threat to the NHS model. First, it would be an enormous policy gamble. While some systems have moved from an insurance-based model to one that is predominantly tax-funded, there has never been an example of a change in the opposite direction. While it is always difficult to make direct comparisons between health systems, it would be very risky to embark on a massive structural reform in the UK without any international evidence about how best to proceed”.<sup>208</sup> Although there is some empirical evidence suggesting that a social health insurance system may be preferable to the current NHS model and we have proposals as to how a British version of social insurance could look, having a concrete case study of a Western European democracy that has developed a centrally-administrated, tax-financed service like the NHS or HSE and subsequently switched to a universal insurance-based Bismarckian system will indeed be valuable. Several Eastern European nations did undergo a change of this nature in the 1990s, but the relevance of these cases to us has been constrained by a lack of political comparability, and while the Netherlands did substantially overhaul its system in 2006, their previous model was still essentially social insurance-based. Therefore, the fact that Ireland is now preparing to cross this Rubicon and make a course-change towards social insurance is significant. Additionally, Ireland’s intensifying discussions around what will need to be included within the official state-mandated basket of treatments for UHI are also worth following as a potential example, in light of current fiscal pressure on the NHS, the risk of rationing and some resultant calls in the UK for long-term clarity over what the NHS should guarantee for patients.

Further, the fact that this is occurring in Ireland is all the more important from a British standpoint, as in terms of cultural similarities, population health profiles, health system and existing problems, the Republic of Ireland is a decent and familiar comparator for the UK – it is after all the only foreign country we share a land border with. British policymakers would be well-served to take advantage of the unfolding example we have in front of us, follow events in Ireland closely and learn from both their successes and stumbling blocks as they go about making this bold change.

### **Relative consensus over radical reform under difficult circumstances**

Moreover, Ireland's reforms are an inspiring example in that they are occurring amid difficult economic and fiscal circumstances and the need for huge savings in healthcare. Just as the NHS was founded in tough economic circumstances in 1948, it may be the case that Ireland may finally draw up an effective and equitable healthcare system under conditions of great adversity. Further, the UHI reforms have been ushered in by a coalition government consisting of the centre-right Christian democratic Fine Gael party and the centre-left social democratic Labour Party, based on separate but comparable UHI plans each party put forward before the last Irish election. The support of the pro-market Fine Gael for decentralisation and UHI is perhaps instinctive to a degree, though laudable. However, the Irish Labour Party's pre-election commitment to its own version of UHI is particularly notable from a British standpoint, demonstrating that the centre-left's essential commitment to universal free at the point of use healthcare can be embodied within a plan for a decentralised social insurance system with a clear contributory link, independent non-profit providers and some degree of competition between insurers. It could be of benefit to the UK if our political parties would take the opportunity to learn from their close cousins and follow suit in embracing social insurance, along the lines of either the Labour or Fine Gael UHI plans, as an equal or superior option to centralised administration for the delivery of universal healthcare.

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