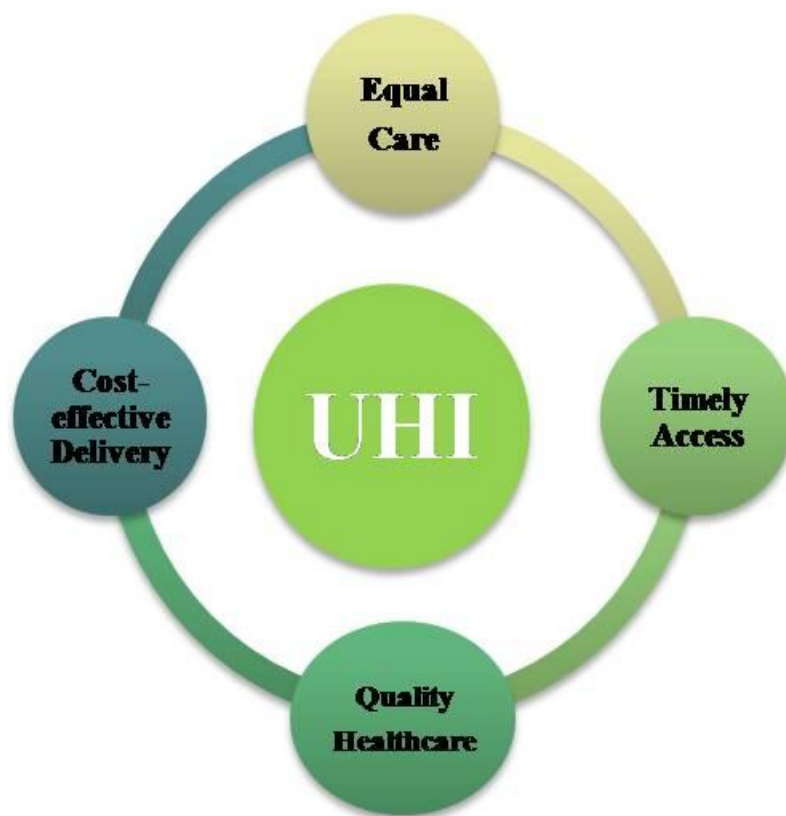


# The Path to Universal Healthcare

## White Paper on Universal Health Insurance



April 2014

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## **Foreword**



*I believe that to achieve a fair and just society, we must have a universal, single-tier health service with access based on need, not income. The Programme for Government commits to achieving this objective through a system of universal health insurance, in which everyone is enrolled with their health insurer of choice. The Government will subsidise those who cannot afford health insurance and health services will be provided by a range of public and private providers. I believe that, together, we can build a high quality service which meets our needs for the future. We will consult widely on our proposals for universal health insurance, and we will listen carefully to people's views as we develop the detail of our plans.*

*Over the last three years the Government has initiated a series of reforms in the health sector which are improving the nation's health, developing services, making efficient use of resources and forming the building blocks for the future system of universal health insurance.*

*The introduction of universal health insurance will be the most radical reform of the Irish health system since the foundation of the State. People are rightly concerned about potential cost implications of any major reform. I am determined that total spending by the State on healthcare in Ireland under a single-tier UHI system should not exceed its total spending under the two-tier system which it replaces. Between now and introduction of the new system I will continue to implement measures to control costs in the public and private healthcare sectors and will ensure that proposals for universal healthcare are fully costed, and compliant with Government expenditure targets.*

*Implementing universal health insurance will take time and careful planning. We will put the major building blocks in place during the lifetime of this Government, with full implementation of the new system by 2019. This White Paper sets out the key elements of Government policy on the system of universal health insurance for Ireland. While we have examined the systems in place in various countries, the*

*model which we are proposing is one designed to meet the needs of the Irish people.*

*Given the fundamental nature of the reforms proposed the Government believes that consultation with citizens and other stakeholders is crucial as we finalise our plans for the new system. This consultation will be taken forward in two ways – a general consultation on the White Paper itself which will start immediately and a consultation on the basket of health services which should be available under universal health insurance and the values system which should underpin future decisions on the provision of services. The Oireachtas Joint Committee on Health and Children will play an active role in this consultation and I would urge people to participate in these consultation processes which will be conducted in an inclusive and transparent manner.*

*Together we can build a new health system which will be sustainable and achieve the best health outcomes for the Irish people*

*Dr James Reilly, TD*

*Minister for Health*

## *Executive Summary*

- Ⓒ The Government is committed to ending the unfair, unequal and inefficient two-tier health system and to introducing a **single-tier system**, supported by universal health insurance, which:
  - ✓ delivers proactive, integrated care at the lowest level of complexity that is safe, timely, efficient and as close to home as possible,
  - ✓ provides equal access based on need rather than ability to pay,
  - ✓ provides choice for the consumer in relation to who insures them,
  - ✓ drives the wider ‘whole of Government’ approach to health in all policies, and
  - ✓ delivers true value for the Irish people.
  
- Ⓒ The Government will achieve a single-tier system via a **multi-payer model of universal health insurance** (UHI), in line with the Programme for Government (PfG), involving competing private health insurers and a State-owned VHI. UHI will be gradually rolled out over several years, with full implementation by 2019 at the latest.

### **The Programme for Government**

- Ⓒ The 2011 PfG commits to the introduction of a single-tier, multi-payer model of UHI covering both hospital and primary care. Social and long term care will remain directly funded by the State. The PfG does not seek to adopt a free market approach to the provision of healthcare services. Nor does it seek to retain the current model which is dominated by a single provider with prices largely set by the State. This model has not proved to be effective in an Irish context. Instead, it commits the Government to rolling out a highly regulated form of multi-payer UHI, with a public option, with the State continuing to play a central role in Irish healthcare. The “legislative and organisational groundwork” for UHI will, the PfG states, be completed within the “Government’s term of office”.
  
- Ⓒ UHI as set out in the PfG will deliver:
  - ✓ *A more decentralised model of healthcare through the creation of a purchaser-provider split.* The PfG states that: 1) The HSE “will cease to exist” and a “purchaser-provider” split will take its place, underpinned by a “Money Follows the Patient” financing system; 2) The purchasing side of UHI will be built around a system of “competing insurers” with a “public option”. “Everyone will have a choice” of

insurer; 3) The provider side of UHI will also be reformed with hospitals reorganised into a series of “not-for-profit trusts”, i.e., all public hospitals will continue to be publicly owned.

- ✓ *Equal access to care through a single-tier system of health.* The PfG states that: 1) The Government “is committed to developing a universal, single-tier health service.” It will “end the unfair, unequal and inefficient two-tier health system.” 2) Insurance payments will be “related to ability to pay. The State will pay insurance premiums for people on low incomes and subsidise premiums for people on middle incomes”; 3) UHI will deliver an “integrated system of primary and hospital care”, supported by GP care without fees for “all”.
  
- ✓ *A continued strong role for the State.* The PfG states that: 1) UHI will be “guaranteed by the State” and underpinned by a statutory framework which includes “compulsory” health insurance for all, supported by community rating and a system of risk equalisation; 2) The State under UHI will control those costs “for which central control is most effective”; 3) The Minister for Health will determine the package of care to be covered by UHI and will put in place a number of measures to guarantee patient safety, including a Patient Safety Agency.

## **The Model of Universal Health Insurance**

- Ⓔ Under the model of UHI for Ireland, every member of the population will purchase a **universal health insurance policy** from their preferred insurer. This policy will provide cover for a comprehensive package of healthcare services.
  
- Ⓔ People will enjoy a number of important protections when purchasing their UHI policy, including the right to be accepted by their chosen insurer and to switch insurer annually (**open enrolment**), the right to renew their UHI policy (**lifetime cover**), the right to be charged the same premium for the same policy regardless of age or risk profile (**community rating**) and the right to equal access to healthcare based on need and not ability to pay (**equal access**). In addition, a system of financial support will ensure affordability by paying or subsidising UHI premiums for all those who qualify.
  
- Ⓔ Applications for **financial support** will be managed by a new National Insurance Fund situated within the Healthcare Commissioning Agency. The Fund will assess each applicant’s entitlement to financial support having regard to the person’s means and also to an overall monetary threshold called the ‘efficient market rate’.
  
- Ⓔ The ‘**efficient market rate**’ refers to a reasonable UHI policy premium offered by an average efficient insurer. The value of the ‘efficient market rate’ will represent the maximum value of financial support payable towards the cost of a UHI policy premium. As such, the ‘efficient market rate’ is designed to protect those on low incomes, and also

to protect the taxpayer, by stipulating the maximum monetary threshold which the State may pay. Further legal and policy analysis will be undertaken to determine the appropriate authority responsible for setting the ‘efficient market rate’.

- Ⓒ Having determined a person’s entitlement to financial support, the National Insurance Fund will manage the payment of support to each person’s preferred insurer, including managing the redirection of payments where a person switches insurer.
- Ⓒ In addition to managing the financial support system, the State will also fulfil several important regulatory and administrative roles relating to:-
  - determining the **standard UHI package**, including the minimum and maximum out of pocket payments which may be applied as part of that package;
  - managing the **system of prior authorisation** where a person wishes to obtain care in another jurisdiction;
  - purchasing UHI policies on behalf of all those who fail to take out cover (**‘cover of last resort’**);
  - **regulating the health insurance market**, including operating a system of risk equalisation and managing a fund to meet the costs associated with insurer insolvency;
  - **regulating the healthcare provider market** from the various perspectives of quality and safety of services, corporate, clinical and financial governance, and management of access arrangements;
  - establishing new processes to support practical and timely **resolution of contractual disputes** between insurers and healthcare providers;
  - establishing robust **health information governance arrangements**, and
  - **managing certain healthcare costs centrally**, including directly financing those services which remain outside the UHI system (e.g. social care services) and establishing a Compensation Fund to meet the emergency healthcare costs of the uninsured.

## The Basket of Services

- Ⓒ In designing the future insurance-based health system, a key question is what services should be provided as part of that system, i.e. what should be included in the health basket? The future **health basket** comprises two major elements: services which are funded via the UHI system as part of the standard UHI package and services which are funded directly by the State and separately to the standard UHI package.
- Ⓒ The question of what services are provided within the health basket goes to the heart of the contract that exists between the State and its citizens. As such, the Government has identified a series of **overarching principles** which will frame this fundamental contract

and ensure that decisions in relation to the health basket are aligned with national health policy goals and with the overall strategic direction of the health service in Ireland:

1. The Irish Government recognises the right of the Irish people to the enjoyment of the highest attainable standard of physical and mental health. In order to support this, the Government will set out in legislation, the entitlement of every person, regardless of personal characteristics and status, to universal coverage for a comprehensive basket of health services and the obligation to contribute to the cost of services, in proportion to ability to pay.
2. In prescribing the basket of health services, the Government recognises health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” As such, it acknowledges that a central role of the health service is to improve the health and wellbeing of people in Ireland.
3. The composition of the health basket should acknowledge the key role of primary care at the heart of the health system. It should also facilitate the delivery of integrated, person-centred care provided at the lowest level of complexity that is safe, timely, efficient and as close to home as possible.
4. The composition of the health basket should reflect a continuous commitment to ensuring that public funds provided by the Irish people are used to optimal effect so that our health service can achieve the best health outcomes for available resources.
5. Services included in the health basket should be safe, effective and of high quality.

In addition to the above guiding principles, the Government has also agreed an initial **process for establishing the health basket** to be provided under the future single-tier health system. The process acknowledges the fact that decisions on the composition of the future health basket are deeply important to Irish people as both the funders and users of the health service and also deeply value-laden. As such, the first stage will involve comprehensive **consultation** with the public, system stakeholders and relevant organisations to develop a **values framework** which embraces the various ethical, economic and technical aspects of service coverage decisions and which will be used in assessing health services and technologies. The second stage will involve applying the



values framework, the findings of the consultation and expert opinion to make **detailed options** in relation to the future health basket. The Oireachtas Joint Committee on Health and Children will play an integral role in this process by facilitating hearings with health system stakeholders and representative groups.

- ④ The detailed options on the future health basket will address (1) the precise array of services to be covered in the standard UHI package and funded via UHI and (2) the services to be funded outside of UHI but still provided as part of the overall health basket, i.e. provided by the national public health system.
- ④ The Government will establish a **Commission**, and set its terms of reference, to deliver the above process. The Commission will submit its recommendations on the costed options to the Government. The Commission in its costing model will assess the degree to which demand for services is likely to change under UHI. The determination of which elements are included in the final composition of the health basket will rest with the Government subject to the approval of the Oireachtas.
- ④ In order to guide and focus the work of the Commission, the Government has developed overarching **policy proposals on the composition of the future health basket**. It is intended that these policy proposals will form the basis of consultation and the starting point for developing detailed recommendations, after which the Government will make final decisions on the health basket.
- ④ The Government's policy proposals set the **strategic policy direction for each of the major health and social care service programme areas** and stipulate three key criteria to govern design of the future health basket:
  - To the greatest extent possible, and to support the move to integrated care, services should be defined by reference to health needs and the nature of the service provided and not by reference to a specific healthcare professional or setting. This will enable continuous innovation and the appropriate use of best practice models and skill mix.
  - To ensure uniformity across the domains of healthcare entitlements and healthcare commissioning, services should be defined using the same, standard classification system for the purposes of both the UHI standard package and the UHI payment mechanism.
  - Services should be defined by reference to national licensing requirements and quality standards.
- ④ The inclusion of pharmaceuticals (subject to co-payments) either as part of the standard UHI package or through a separate eligibility scheme replacing both the current General Medical Scheme and Drugs Payment Scheme will be considered. In particular, the

Government wishes to continue to cover the drugs costs of the lowest income group, as currently applies to those with medical cards.

- Ⓢ Core services such as health and wellbeing services, long-term mental healthcare and social and continuing care services will continue to be provided by the public health system and would be funded separately to UHI.
- Ⓢ Finally, following the initial process of setting the health basket, the Minister for Health, in conjunction with the Minister for Public Expenditure and Reform, will **regularly review** and update the basket. Ongoing management of the basket will involve the following four tasks:
  - A. Assessing new technologies and treatments in order to support the Minister in adding new services to the health basket
  - B. Reviewing existing technologies and treatments to support the Minister in removing outdated and inappropriate services from the basket
  - C. Updating the values framework which underpins and supports the assessment of treatments and technologies
  - D. Adjudicating on disputes between purchasers and providers and between purchasers and members of the public in relation to the interpretation of the health basket.
- Ⓢ Given the structure of the future insurance-based health system, each of the above functions must be assigned to a single, clearly designated authority with a remit which extends across all sectors of the future health system. Having considered several policy options, the Government has decided that the **Health Information and Quality Authority** (HIQA) is the body best placed to undertake these functions. This is due to HIQA's existing expertise in relation to health technology assessment, its broad remit in setting quality standards across the health and personal social services area, and its solid reputation as an independent authority which stands apart from all purchasers and providers.
- Ⓢ HIQA is already renowned for establishing robust and transparent processes to underpin the effective discharge of its functions. Consistent with this approach, when assessing new and existing services (i.e. functions A and B above), HIQA will adopt a **transparent and standardised decision-making process**. This will entail making assessment procedures publicly available, publishing the outcome of individual assessments and engaging with stakeholders prior to finalising and submitting recommendations to the Minister. In regard to function C above, HIQA will seek approval from the Minister to update the values framework.
- Ⓢ With regard to resolving disputes on the health basket (i.e. function D above), the Government plans to establish a **practical and independent adjudication process** in order to avoid potentially expensive and protracted legal action, and to safeguard the

public's interests. However, as such disputes will ultimately be a matter of private contract law, the adjudication process will not preclude any person from seeking redress via the Courts.

## **Funding Universal Health Insurance**

- Ⓔ Having considered the services to be provided in the future health system, the next related question is how do we fund those services? The Government's preferred model of UHI provides the overarching **template for future financing arrangements**, whereby:
  - 1) people will pay their UHI premium directly to their chosen insurer;
  - 2) the State will supplement private premiums by making financial support payments directly to insurers on behalf of qualifying individuals;
  - 3) the State will also directly finance certain other UHI services or costs (e.g. ambulance services), and
  - 4) the State will continue to fund certain other health and social services which fall outside the standard UHI package (e.g. long-term residential care).
- Ⓔ The Government has explored various options for funding the State's obligations in relation to financial support payments and direct service costs under UHI (i.e. State-funded elements 2 and 3 above) and has decided to retain **general taxation** as the core mechanism for raising resources. However, it plans to introduce some important changes in terms of how these resources are allocated, pooled and managed.
- Ⓔ Firstly, Government allocations to the UHI system will take account of the 'efficient market rate', the numbers qualifying for financial support and the average amounts of financial support payable having regard to income levels/ means-test criteria etc.
- Ⓔ Secondly, allocations to the UHI system will be **centrally pooled in the National Insurance Fund**. As already indicated, the Fund will have responsibility for directly financing certain UHI services and for managing financial support payments to insurers. Aligned with this latter task, it will also take on two additional financing functions as follows:

**Management of Payments related to Standard Tax Relief:** The existing system of standard tax relief on health insurance is already a subsidy to the private health insurance market. Running two separate systems of financial subsidy undermines transparency and is administratively inefficient and wasteful. On the assumption that tax relief on premiums continues (an issue which the Government will consider as a part of tax-policy in each of the Budgets up to the time of introducing UHI) it is also proposed to subsume it into the overall system for financial support for UHI on a revenue neutral basis. A base payment would be paid on behalf of everyone through the Insurance Fund with additional financial support payments linked to a means test and ability to pay.

***Management of Risk Equalisation Payments:*** Consistent with the move to a single, integrated system, it is suggested that risk equalisation stamp duties would also be pooled into the National Insurance Fund which would then be responsible for managing the payment of risk equalisation credits to insurers. This will allow the Fund to manage financial transfers in respect of both income status (i.e. financial support payments) and risk status (i.e. risk equalisation payments) in the most efficient manner, including the use of singular transactions where appropriate. It also facilitates greater transparency and enables the linking of anonymised datasets for the purpose of gaining a deeper understanding of drivers of population health need.

Ⓒ The above approach to managing resources means that all State funding for UHI:

- ✓ is collected by the same, single authority, the Revenue Commissioners,
- ✓ is ultimately pooled into the same, single entity, the National Insurance Fund, and
- ✓ is allocated by the same, single entity, the National Insurance Fund.

Ⓒ Finally, when considering funding arrangements, two key questions arise: firstly, what will the overall cost of UHI be? Secondly, how much will people pay for insurance premiums?

## Cost Control

The Government is determined that total spending by the State on healthcare in Ireland under a single-tier UHI system should not exceed its total spending under the two-tier system which it replaces. This approach will allow for cost effective additional investment in health services in line with increases that are consistent with our Constitutional and legal obligations under the Treaty on Stability, Coordination and Governance (the Fiscal Compact) and the Stability and Growth Pact, and it will take account of demographic factors as our population ages.

A major costing exercise will be undertaken on the policy proposals following publication of the White Paper. Progression of proposals on UHI will be dependent on the outcome of this exercise. It will be necessary to:

- Decide and cost the package of health services to be provided under UHI
- Decide and cost the services to be provided in the overall health basket
- Estimate future demand for health services in a UHI environment
- Decide on the proportions of the population to receive a full/partial subsidy
- Devise a formula for the ‘efficient market rate’ and estimate the liability of the State for the provision of subsidies
- Estimate the potential administrative and regulatory costs involved in delivering UHI
- Estimate average premium costs to be paid by individuals.

A series of further measures will be introduced over the next few years, prior to the introduction of UHI, which will provide demonstrable evidence of lower costs and enhanced productivity and efficiency in both the public and private health systems. In addition, the State will maintain specific powers to control costs in a UHI system, should their use be required.

As already highlighted, the ‘efficient market rate’ is an important element of the UHI system which is designed to deliver both financial protection and financial sustainability. It will be complemented by a **suite of cost control measures** comprising (i) the stipulation of prescribed payment methods to be used in all UHI commissioning, (ii) the setting of maximum prices for healthcare providers, (iii) price monitoring of insurers, (iv) capping of the standard tax relief/ subsidy payable on UHI premiums (v) capping of insurer overheads and profits, (vi) capping of insurer claims, (vii) the State will also legislate for the use of overall expenditure ceilings within the UHI system.

A key feature of the system will be the nature of the contracts entered into by the Healthcare Commissioning Agency and by competing private health insurers. Purchasers will negotiate provision of a specified volume and type of service, and will not continue paying additional amounts for extra services that have not been contracted. This is a critical means of helping to prevent supplier-induced demand; purchasers’ funds raised by premiums, whether paid for by the State or private individuals, will effectively set the upper limit of what will be paid for.

Premium prices in 2019, five years from now, will ultimately be established in a competitive health insurance market. However, it is likely that these premium prices will be driven by four key variables:

- ❖ The total cost of healthcare in 2019 taking account of both the impact of further efficiency improvements in the health system and likely demand for services. A likely fall in the number of people on medical cards over the next five years, driven by economic recovery, should help reduce the pressure on health budgets. However, other factors are increasing demand, e.g., the number of people over 65 is growing steadily;
- ❖ The precise composition of the UHI package. This will only be determined once the consultation exercise on the future health basket is completed;
- ❖ The balance of funding for UHI between tax revenue, co-payments and insurance premiums. The larger the contribution from tax revenues and co-payments, for instance, the lower the contribution required from insurance premiums. Ultimately, this will be determined by Government fiscal and tax policy in 2019; and

- ❖ The likely degree of price competition between the insurance companies as UHI is introduced. Insurance companies will, for instance, be able to offer lower premiums for plans that include different co-payment/excess levels.

## Key Building Blocks and Next Steps for UHI

- © The introduction of UHI represents the most radical, most fundamental reform of our health service in the history of the State. It is vital that we lay solid foundations to support the new system. This involves putting in place a wide range of **building blocks** as follows:
  - ❖ **Structural building blocks:** These are the reformed organisational structures which need to be put in place such as a Healthcare Commissioning Agency, independent Hospital Trusts and new primary and community care organisations. The Department of Health will also be strengthened ahead of the HSE Vote returning to it in 2015.
  - ❖ **Regulatory building blocks:** This encompasses the new regulatory systems, structures and functions which need to be established, for example, a new licensing regime for healthcare providers and a robust risk equalisation scheme for the private health insurance market.
  - ❖ **Financial building blocks:** This refers to the new financial mechanisms and processes which are required to prepare for the future insurance-based health system such as the introduction of programme based budgeting and Money Follows the Patient payment mechanisms which will cover both the public and private health systems.
  - ❖ **Information building blocks:** This encapsulates the new information systems, structures and governance requirements which are necessary to effectively manage and steer the UHI system, e.g. unique identifiers, Health Information Bill etc.
  - ❖ **Integrated care building blocks:** This relates to the need for new structures to deliver patient-centred integrated care. Proposals will be published later this year outlining how new structures will deliver such care.
- © Collectively, the above building blocks form the bridge which will allow us to travel from our current health system to our future destination of UHI. That journey will encompass **three major and overlapping stages**, namely (1) structural reform of the health services, reform of the private health insurance (PHI) market, and phased roll out of universal primary care to the whole population (2) the passing of Health Reform legislation which will abolish the HSE; and (3) the phased introduction of UHI from 2016 onwards, with all appropriate legislative and organisational groundwork completed during this Government's term of office.

- ④ UHI will require the integration of the public and private healthcare systems. As part of the preparatory work for this integration process, the Minister for Health will initiate a process of engagement with: i) the private hospital sector to explore their future role in an integrated hospital system for Ireland; and ii) the health insurance companies to explore their future role in the rollout of universal primary and hospital care.

# 1. Understanding Our Starting Point

## 1.1 Introduction

Good health is the greatest asset of any individual or society. It is fundamental to enabling a people to prosper and to realise their full potential socially, economically and creatively. This Government is committed to improving the health and wellbeing of the people of Ireland. To do this, it has set out an ambitious plan for the most far-reaching and fundamental reform of our health system since the foundation of the State. This reform will see the delivery of a single-tier health system which:

- ✓ delivers proactive, integrated care at the lowest level of complexity that is safe; timely, efficient and as close to home as possible;
- ✓ provides equal access based on need rather than ability to pay;
- ✓ drives the wider ‘whole of Government’ approach to health in all policies, and
- ✓ delivers true value for the Irish people.

The ultimate realisation of this single-tier system will be achieved through universal health insurance (UHI).

The purpose of this White Paper is to provide further detail on the Government’s plans for UHI. It begins by exploring our starting point in terms of understanding health policy goals, the current healthcare system and current and future health needs. Chapter two then considers the major building blocks which need to be put in place to prepare our system for the journey to universal health insurance. Chapters three to five collectively provide the high-level blueprint for the future UHI system, respectively addressing key system design issues such as the model of UHI for Ireland, the standard package of services to be covered by UHI and the mechanisms for funding UHI. Chapter six concludes by mapping out the immediate next steps on the road ahead.

## 1.2 Health Policy Goals and Guiding Principles

At the heart of the Government’s plans on UHI is a desire to improve our health system’s ability to achieve its core purpose. This purpose has been articulated in the Department of Health’s *Statement of Strategy 2011- 2014* as being:

- ✓ to keep people healthy;
- ✓ to provide the healthcare people need;
- ✓ to deliver high quality services, and
- ✓ to get best value from health system resources.



Every step of the health reform programme must be driven by, must deliver on, and must be evaluated against this overall aim. Plans for UHI are, therefore, guided by the following vision statement which captures the high-level objectives of our health service:

**To develop an efficient and effective single-tier health service which promotes equitable access to high quality care on the basis of need.**

In addition to the vision statement outlined above, a number of core principles have been developed to underpin the design of the future system. These are as follows:

- **KEEPING PEOPLE HEALTHY**–The system should promote health and wellbeing by working across sectors to create the conditions which support good health, on equal terms, for the entire population.
- **EQUITY**–The system should provide financial protection against catastrophic out of pocket expenditure through universal coverage of the entire population. A system of compulsory UHI should ensure universal access to healthcare for all citizens based on need rather than ability to pay.
- **QUALITY**–The system should support the best health outcomes for citizens within available resources.
- **EMPOWERMENT**–The system should empower and support citizens, patients and healthcare workers to make evidence-informed decisions through appropriate sharing of knowledge and information.
- **PATIENT-CENTREDNESS**–The system should be responsive to patient needs, providing timely, proactive, continuous care which takes account, where possible, of the individual’s needs and preferences.
- **EFFICIENCY AND EFFECTIVENESS**–Incentives should be aligned throughout the health system to support the efficient use of resources and the elimination of waste and to drive continuous performance improvement and co-ordination across different providers.
- **REGULATION AND PATIENT SAFETY**–Regulatory, governance and payment structures should support the provision of safe, high quality, integrated care based on national standards and protocols, and delivered in the most appropriate setting.

In order to deliver on the above vision, it is necessary to begin by understanding our current health system and the key challenges which must be resolved if we are to achieve an efficient and effective single-tier health service.

## 1.3 The Current Irish Health System

Ireland has both a national public health system and a voluntary private health insurance system. In the case of the public health system, services are largely funded by general taxation and are delivered by a single organisational entity, the Health Service Executive (HSE). By contrast, private health insurance is provided by several, competing private companies and is financed by individual insurance premiums.

While the national public health system provides universal coverage for hospital care, almost 45% of the population nonetheless purchase private health insurance, predominately for the purpose of ensuring faster access to hospital care. While the State is making good progress in reducing waiting times for public hospital services, these access times remain unacceptably long and comparable waiting times for private treatment, while not measured nationally, are accepted as being considerably shorter.

This ‘two-tier’ system of hospital access is underpinned by a two-tier payment structure. Public hospitals receive a block grant allocation in respect of public patient treatment, while charging a ‘per diem’ fee for each private patient<sup>1</sup>. Similarly, consultants get a fixed salary to cover all public patient treatment but are paid a ‘fee for service’ by health insurers in respect of each private patient. Moreover, many consultants are allowed to combine public and private practice and, subject to certain contractual limitations, can treat private patients in either public or private hospital settings. Thus, it has been argued that, for consultants and hospitals with a mix of public and private patients, each private patient is a source of income, while each public patient simply represents a cost. This ‘two-tier’ system of access and funding is widely acknowledged as being both deeply unfair and highly inefficient. Plans to create a fair and efficient single-tier system must, therefore, address this fundamental issue.

A ‘two-tier’ system also prevails within the primary care sector. Ireland is considered unique among EU countries in not having universal coverage for primary care. Instead, eligibility is essentially determined via a means-tested medical card system. Those who qualify for a full medical card are entitled to a range of services free of charge, including GP care. Currently 40.3% of the population hold a medical card, with a further 2.7% qualifying for a GP visit card entitling them to free GP care only. The remainder of the population must pay the full cost of GP care at the point of use. This fragmented approach to primary care is acknowledged as contributing to the current inefficient and hospital-centric model of care.

In conclusion then, the current two-tier system is undermining the development of a modern, responsive and sustainable health service where population coverage and financial incentives encourage the provision of proactive and timely care at the lowest level of complexity and which delivers the best health outcomes for available resources. This is why the Government is committed to a fair and efficient single-tier system which will best serve the needs of the

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<sup>1</sup> Charges for private patients are currently subject to bed designation rules.

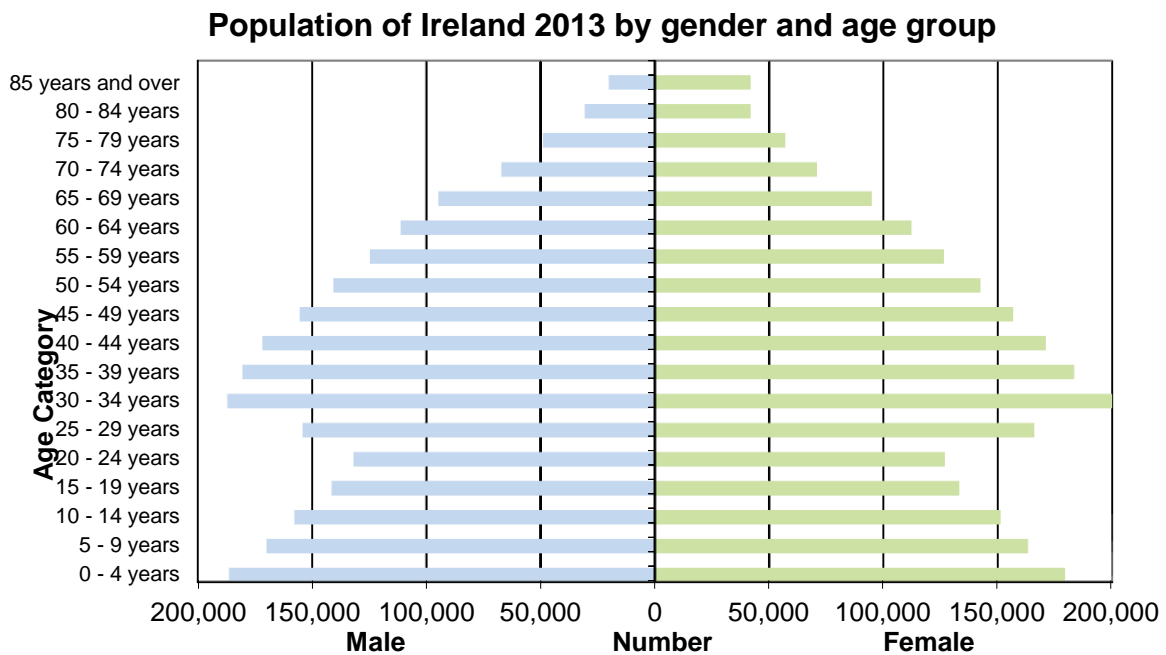
Irish people. In order to design that system, it is important to begin by taking a closer look at those population needs.

## 1.4 Current and Future Population Health Needs

### Who does the Health System Serve?

The Irish population currently stands at almost 4.6 million people<sup>2</sup>. Its composition in age terms is illustrated in figure 1.1 below:

[Figure 1.1. Ireland's Population 2013](#)



In considering the above demographic picture, several issues are notable.

Firstly, Ireland has experienced **strong population growth** over the past twenty years. In recent times, this growth has mainly been driven by very high births combined with falling deaths<sup>3</sup>. Indeed, Ireland's birth rate is by far the highest in the EU<sup>4</sup>. This trend is visible in the demographic pyramid above which illustrates the significant proportion of the female population aged between 30 and 39 and the corresponding large number of 0- 4 year olds<sup>5</sup>.

<sup>2</sup> CSO, website accessed 4 April 2013.

<sup>3</sup> For the 7 year period, 2006 to 2012, total births were 508,973 and deaths were 198,524 (CSO – Note: the number of births and deaths for 2012 are provisional).

<sup>4</sup> *Perinatal Statistics Report 2011*, ESRI, 2012

<sup>5</sup> Between 2006 and 2012, the average annual number of births stood at 72,710 (2012 data is provisional).

However, notwithstanding the recent ‘baby boom’, **our population is also ageing**. Between 2006 and 2013, the population aged 65 years and over increased by 21.4%<sup>6</sup>. This trend will accelerate, with the population aged 65 and over projected to increase by over 50% from its current level of 568,100 to 855,000 in 2026 and by over 74% to 991,000 in 2031. The population aged 80 and over is expected to grow by over 62% from 134,700 in 2013 to 219,100 in 2026 and by over 107% to 279,400 in 2031. The population aged 85 and over is expected to grow at a greater rate from 62,100 in 2013 to 104,100 in 2026, an increase of over 67%, and to 135,500 in 2031, an increase of over 118% (Table 1.1).

To put these figures in the context of the rest of the population, the old age dependency ratio is set to increase from 18.8% in 2013 to 30% in 2031<sup>7</sup>. The overall dependency ratio will increase from 52.2% to 56.8% over the same period. In other words, there will be 1.36 people of working age for every one younger or older person in Ireland.

[Table 1.1: Population Projections and Dependency Ratios from 2013 to 2031](#)

Year	2013	2016	2021	2026	2031
<b>Total Population</b>	4,593,100	4,686,500	4,875,100	5,042,100	5,187,400
<b>O/65 Population</b>	568,100	624,100	731,800	855,000	991,000
<b>80+ Population</b>	134,700	148,500	175,100	219,100	279,400
<b>85+ Population</b>	62,100	69,900	85,000	104,100	135,500
<b>Old Age Dependency Ratio</b>	18.8%	20.7%	23.7%	26.7%	30%
<b>Overall Dependency Ratio<sup>8</sup></b>	52.2%	55.4%	57.8%	57.2%	56.8%

Source: M2F2 Projections by Central Statistics Office

Our population is also becoming **more culturally diverse**. Over half a million non-Irish nationals, representing 199 different nations now live in Ireland<sup>9</sup>. This reflects a 143% increase in the total number of non-Irish nationals over the past decade and accounts for almost 12% of our population. This inward migration has kept Ireland young! Non-Irish nationals have a lower average age than Irish nationals (32.6 versus 36.7 respectively), with 60% of all non-Irish nationals aged between 22 and 44 years. However, while migration has contributed to population growth, since 2009, it has resulted in a **net outflow from Ireland (emigration), with 80-90% of emigrants in the age range of 15 to 44 years**<sup>10</sup>. It is currently difficult to predict what longer-term migration patterns will look like and what impact they may have on our overall dependency ratio.

<sup>6</sup> *Health in Ireland - Key Trends 2013, Department of Health, 2013.*

<sup>7</sup> The forecasted old age dependency ration in 2031 is contingent upon various assumptions in relation to migration.

<sup>8</sup> This is defined as the sum of those aged 0-14 and those aged 65+ divided by those of working age, i.e. 15-65 year olds.

<sup>9</sup> Census 2011 records 544,357 non-Irish nationals living in Ireland. Twelve nations accounted for 74.4 per cent of all non-Irish nationals in 2011. A further 34 nations accounted for 20.6 per cent of the non-Irish nationals in Ireland. Source: *Census 2011 Profile 6 Migration and Diversity - A profile of diversity in Ireland*, CSO, 2012

<sup>10</sup> *The changing landscape of Irish migration, 2000- 2012*, National Institute for Regional and Spatial Analysis, 2012

In addition to increasing cultural diversity, there is also a steady trend towards **increased urbanisation**. While, generally speaking, Ireland has a small, geographically dispersed population, in 2011, almost half the population lived in cities or towns of more than 10,000 people and more than half the population lived in Leinster, with 1.27 million of these living in Dublin. However, while Irish people may be more likely to live in cities and towns than ever before, they are also more likely to live in **smaller households**. There are currently 1.65 million private households in Ireland with an average household size of 2.7 persons<sup>11</sup>. The majority of households (70.1%) contain families<sup>12</sup>, with an average of 1.4 children per family. A further 23.7% of households are single occupancy, while the remaining 6.2% are non-family households.

There is a **stark correlation between age and living alone**. Nearly 28% (136,295) of people aged over 65 years in private households live alone. The percentage increases to 36.7% of people aged 75 and over and 44.2% of people aged 85 and over living on their own. Elderly people living alone are predominantly women. In fact almost two-thirds of elderly people aged 65 and over who live alone are women. This increases to almost three in every four for those aged 85 and over. This trend is important when thinking about some of the highest risk users of health and social care services.

## Who has the Greatest Need for Healthcare?

As demonstrated above, our population is ageing and this trend is set to accelerate. As our population ages, **total healthcare costs are likely to increase**. While predicting the consequences of population ageing is complex, estimates from other countries suggest that the pure effects of ageing will increase demands on services by between 1 and 2% per annum<sup>13</sup>. Data from our own public and private healthcare systems also highlights this relationship between ageing and cost. Under the General Medical Services (GMS) system, the pharmaceutical costs incurred by a 70 year old are almost 7 times greater than those incurred by a 20 year old while, within the private health insurance market, the average claims costs associated with a 70 year old are 10 times those of an average 20 year old.

Healthcare needs are also significantly influenced by socio-economic status and income. Evidence suggests that **people with lower incomes have poorer health and higher incidence of disability and chronic disease**. This trend applies across the EU, with people in the lowest income quintile more likely to report their health as “very bad” compared to people in the highest quintile. However, in Ireland, the relative difference between the

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<sup>11</sup> The number of private households increased by 60.7 per cent since 1991, from 1,029,084 to 1,654,208 in 2011. Over the same period the average household size decreased from 3.3 persons per household to 2.7 driven by the growing number of one person households and falling family size. Source: *Census 2011 Profile 5 Households and Families - Living Arrangements in Ireland*, CSO, 2012

<sup>12</sup> For census purposes, a family is defined as a couple with one or more children, a couple without children or a lone parent with one or more children. Within this broad category, by far the most prevalent household type, across households headed by both Irish nationals and non-Irish nationals, was a couple with children.

<sup>13</sup> *Report of the Expert Group on Resource Allocation and Financing in the Health Sector*, Department of Health, 2010

percentage reporting “very bad” health in the highest and lowest income quintiles is greater than for any other EU country, i.e. the disparities in health status are greater.

Not surprisingly, this poorer health status appears to translate into a **greater need for healthcare services**. Medical card holders (many of whom are on lower incomes) consult the GP two and a half times more than people without medical cards and are higher users of hospital services, a trend which essentially holds across all age groups<sup>14</sup>. Furthermore, it is notable that this trend holds notwithstanding the fact that those on lower incomes may wait longer to access services and may report higher levels of unmet need than those with higher incomes and private health insurance<sup>15</sup>.

Finally, in considering the distribution of healthcare need and utilisation across our population, perhaps the most striking issue from a health system design perspective is not the impact of ageing or income but, rather, the fact that **the majority of healthcare resources are used by a minority of the population**. Research from the United States indicates that 64% of all healthcare costs relate to only 10% of the population, while half of the population absorb only 3% of all healthcare costs<sup>16</sup>. Moreover, of the 64% of costs attributed to high-users, it is suggested that almost half of these costs (or approx. 30% of total healthcare spending) relates to 1% of the population<sup>17</sup>. The Nuffield trust in the UK illustrates this phenomenon in the figure below.

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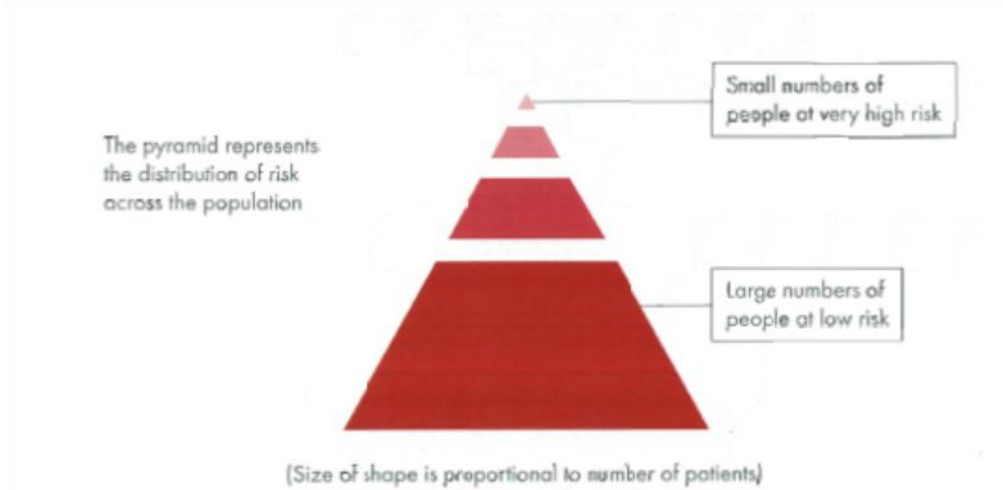
<sup>14</sup> HIPE data from 2011 indicates that, while medical card holders account for 41% of the population, they account for 50% of all inpatients and 60% of all daycases and inpatient bed days. Excluding those over 70 (who enjoy almost universal medical card coverage), the trend holds for all age groups except those aged 0-4 years and 30- 40 years (traditional childbearing years). Similarly, CSO data published in 2011 illustrates that 40% of medical card holders reported at least one hospital attendance compared with 31% of private health insurance holders and 21% of those relying only on general public health cover.

<sup>15</sup> OECD research from 2011 finds that Irish people in the lowest income quintile are 3.6 times more likely to report unmet medical needs than people in the highest income quintile, with waiting times being a common reason given for unmet need.

<sup>16</sup> Emanuel, Ezekiel, *Healthcare Reform and the Future of American Medicine*, Presentation delivered at the Amnesty International Ireland AGM in 2011. Weiner, Jonathan, *Risk Adjustment Opportunities and Challenges: Our US and UK experiences*, Presentation delivered at Nuffield Trust Risk Adjustment Conference on 29<sup>th</sup> June, 2011.

<sup>17</sup> Weiner, Jonathan, *Risk Adjustment Opportunities and Challenges: Our US and UK experience*.

Figure 1.2: Distribution of Risk in the Population



(Source: *Predictive Models for Health and Social Care: A Feasibility Study*, Nuffield Trust)

In Ireland, resource usage seems similarly concentrated in 10% of the population. Hospital In Patient Enquiry Scheme (HIPE) data indicates that the top 10% of high users of acute inpatient services account for over 50% of all inpatient bed days<sup>18</sup>. Moreover, half of these (the top 5%) account for almost 40% of all inpatient bed days.

Research further indicates that high users of health services often suffer from multiple chronic conditions. However, the evidence also suggests that many of these chronic conditions could be managed more effectively. The US National Institute of Health reports that, across six chronic conditions, potentially avoidable complications account for 15-20¢ of every dollar spent on acute hospitalisations and procedures and for 40¢ of every dollar spent on overall healthcare<sup>19</sup>. This suggests that 40% of US healthcare resources are spent on problems that should not have arisen with quality preventative care and active condition management. This fact, coupled with the evidence on population distribution of health costs, underscores the need for the future health system to identify high risk individuals and actively manage their care needs in order to deliver better, more responsive care, reduce cost and remain sustainable. These issues are returned to in later chapters.

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<sup>18</sup> Information is based on Department of Health analysis of the HIPE 2011 dataset.

<sup>19</sup> Emanuel, Ezekiel, *Healthcare Reform and the Future of American Medicine*, Presentation delivered at the Amnesty International Ireland AGM in 2011.

## 2. Building Blocks for Universal Health Insurance

### 2.1 Introduction

The introduction of UHI represents the most radical, most fundamental reform of our health service in the history of the State. It is vital that we lay solid foundations to support the future UHI system by carefully and systematically preparing each and every aspect of the health landscape for the major transition which lies ahead.

In order to do this, a ‘whole system’ programme of health reform is underway. This programme involves putting in place a wide range of structural, financial, regulatory and other building blocks with the ultimate, overarching aim of delivering UHI. It is overseen by a dedicated Programme Management Office, the aim of which is to manage the overall blueprint for health reform and ensure that all building blocks are planned and progressed in a coherent manner and in line with the overall vision.

This chapter outlines some of the most important building blocks and takes a look at each in terms of the overall policy vision, progress to date and planned next steps. To aid the reader, these building blocks are grouped by:

- ❖ **Structural building blocks:** These are the reformed organisational structures which need to be established such as a Healthcare Commissioning Agency and independent Hospital Trusts.
- ❖ **Regulatory building blocks:** This encompasses the new regulatory systems, structures and functions which are being put in place, for example, a new licensing regime for healthcare providers and a robust risk equalisation scheme for the private health insurance market.
- ❖ **Financial building blocks:** This refers to the new financial mechanisms and processes which are required to prepare for the future insurance-based health system such as the introduction of programme-based budgeting and Money Follows the Patient payment mechanisms.
- ❖ **Information building blocks:** This final, important category encapsulates the new information systems, structures and governance requirements which are necessary to effectively manage and steer the UHI system, e.g. unique identifiers, Health Information Bill, etc.



Collectively, these building blocks form the bridge which will allow us to travel from our current system to our future destination of UHI.

## 2.2 Structural Building Blocks

### Creation of Interim Structures

The move to an insurance-based health system requires radical transformation of our existing public sector structures. In short, it involves shifting from our current centralised healthcare model, whereby a single, national entity is tasked with the financing, organisation and delivery of health services, to a decentralised model involving multiple healthcare purchasers and providers. This, in turn, demands the dissolution of the HSE into a range of new organisations, each with its own distinct legal identity. As highlighted in *Future Health*, this process of dissolution must happen in three carefully managed stages, namely:

- the creation of new healthcare directorates within the HSE,
- the creation of a formal purchaser/ provider split through the establishment of a Healthcare Commissioning Agency and new healthcare provider structures, and
- the introduction of UHI.

The first stage has already been successfully completed with the introduction of a new **Directorate Model** within the HSE. The model is underpinned by the *Health Service (Governance) Act 2013*, which provides for new, statutory governance arrangements in the form of a directorate, headed by a Director General. As well as replacing the HSE board structure with strengthened, more streamlined governance and management arrangements, the new Directorate will lead the reorganisation of services to prepare the way for UHI. This will involve the directorate management team having a clear budget or ‘Fund’ for each relevant service domain and a mandate to deliver sustained performance improvement across that domain. In each case, this mandate will translate into two core and inter-connected missions:

- to develop strengthened frontline provider structures, and
- to establish enhanced accountability arrangements via new performance contracts, underpinned by Money Follows the Patient payment systems where appropriate.

As such, the work of the directorate represents an important precursor to the achievement of a formal purchaser/ provider split.

The subsequent transition to a full purchaser/ provider split will be realised through the creation of a new **Healthcare Commissioning Agency**. The Agency will encompass the funds previously managed by the HSE directorates as well as the directorate management teams with responsibility for performance contracting and financing. The Agency will have national responsibility for purchasing healthcare services. As such, it will be responsible for transforming national policy priorities and targets set out by the Minister for Health into detailed performance contracts with healthcare providers, and then managing all payments to

those providers. The performance contracts in question will explicitly link payment with the achievement of targets across the spectrum of quality, access and activity.

The full purchaser/ provider split necessitates the creation of formal healthcare provider structures. As such, the new Healthcare Commissioning Agency (as purchaser) will be complemented by new primary and community care structures and independent Hospital Trusts (as providers). Further detail on these new provider structures is set out below.

The final stage of structural reform will see some of the purchasing functions of the Agency transfer to **competing private health insurers**. However, the Agency will retain responsibility for purchasing services which fall outside the standard UHI package of care. As such, the agency will still have a central role in financing certain services and in working with health insurers to support the delivery of high quality, integrated care. In addition, a National Insurance Fund within the Agency will have responsibility for managing financial subsidies to support the affordability of UHI premiums as well as meeting certain other UHI-related costs (see chapters 3 and 4 for further details).

## Creation of Hospital Trusts

The Government is committed to the transformation of public hospitals into independent, not for profit Hospital Trusts. As a first step in this process, public hospitals are currently being organised into more efficient and accountable Hospital Groups in line with the recommendations of two expert reports published in May 2013, namely *The Establishment of Hospital Groups as a Transition to Independent Hospital Trusts* and *The Framework for Development – Securing the Future of Smaller Hospitals*.

Seven Hospital Groups have been established, each of which will operate under a single, management structure. The Groups are:

- (i) Dublin North East; (ii) Dublin Midlands; (iii) Dublin East; (iv) South/South West; (v) West/ North West; (vi) Midwest, and (vii) Children's.

Chairpersons have now been appointed to all Hospital Groups. Key next steps include the appointment of remaining Board members, in discussion with the Chairs, and the recruitment of Group CEOs through an open competition led by the Public Appointments Service which commenced in November, 2013.

In order to progress implementation of the recommendations of the two expert reports, the Department of Health is developing an overarching policy framework to guide hospital services reorganisation from a national standpoint. A Strategic Advisory Group (SAG) has been established, with the appointment by the Minister of a Chair and 12 members in December 2013. The Group will provide objective advice and expertise to the Department, HSE and Hospital Groups and oversee the establishment of Hospital Groups and the subsequent reorganisation of acute hospital services. The first focus for the SAG will be to

provide guidance and expert input into the development of the overarching policy framework. As implementation progresses, the SAG will develop the criteria by which the strategic plans of each Hospital Group will be approved and implementation subsequently evaluated. It will also provide ongoing advice and expertise on complex issues that will arise during implementation.

The creation of Hospital Groups represents a critical step in improving hospital performance and, ultimately, patient outcomes. In the immediate term, the Hospital Groups will harness the benefits of increased independence and greater control at local level, while, over time, they will make the transition to fully competing Hospital Trusts in the context of a universal insurance-based health system. This will involve the development of a legislative framework for Hospital Trusts and agreement in relation to an implementation plan for the formal establishment of Trusts. This process will involve detailed examination of issues such as capital raising powers and continued State investment in national speciality/strategic services. It will also examine the question of intervention by the State, should it become necessary, in order to support a healthcare provider which is critical to meeting population needs.

## **Creation of New Primary and Community Care Structures**

Alongside the creation of independent Hospital Trusts, and as part of reformed organisational structures, the Government intends to introduce strengthened primary and community care structures. In order to inform decisions on the optimal future structures to best support delivery of primary and community care, the Minister for Health initiated a Review of Integrated Service Areas, which was carried out by the HSE and is now complete. A major consultation process has been completed and design options are currently being finalised in relation to the scale, number, geographical remit, governance and management structure of the proposed successor bodies. The report will be a key input to the detailed decisions to be taken in relation to our overall health structures.

## **Establishment of a Healthcare Pricing Office**

In February 2013, the Minister published a new *Money Follows the Patient Policy* which indicated that purchasing and price-setting functions should be delivered by two separate entities in order to safeguard the integrity of the commissioning process. Therefore, in addition to establishing an interim purchaser of healthcare services, it is also necessary to create a Healthcare Pricing Office to act as a national price-setter. The Office was established on an administrative basis, attached to the HSE, in January 2014. It is intended that the Office will become a statutory office at a later point. The primary functions of the Office are to set the national Diagnosis Related Group (DRG) prices for the Money Follows the Patient system and to manage the HIPE dataset. As such, the Office will initially support the work of the Directorates, and later the work of the Healthcare Commissioning Agency, in moving to a value-based purchasing model underpinned by pre-agreed performance contracts and prices. In addition to setting prices for hospital services in the first instance, it will also take on the current NTPF function of negotiating prices for nursing homes under the Fair Deal scheme.

## **Establishment of a Patient Safety Agency (PSA)**

Finally, the Government plans to establish a new Patient Safety Agency which will have an advocacy role in relation to patient complaints, supporting patients so that they can secure a response regarding the issues they raise. Based on a detailed analysis of complaints throughout the system, the PSA will provide national leadership for patient advocacy services, including the Health Service Charter *You and Your Health Service*.

The PSA will build on the existing functions of the Quality and Safety Directorate in the HSE. This will represent a major step in improving safety and quality. Discussions are continuing between the Department and the HSE on establishing the Agency initially on an administrative basis within the HSE structures in 2014. The HSE is expected to establish a Board to oversee the PSA and to agree its initial governance and operational arrangements. The initial focus of the PSA will be on leadership and capacity building for patient safety, adverse event learning and clinical audit.

In addition, the health and social service regulatory function will be maintained separately from the PSA and enhanced within HIQA, with the latter retaining responsibility for setting and monitoring standards (see below).

## **Human Resources**

The structural changes described above represent a major shift in how we organise and deliver our health and personal social services. The Government is conscious of the concerns and rights of everyone working in the health system. The organisational reform will be implemented having full regard to the needs of staff, including their existing rights under agreed industrial relations procedures. Employment rights will also be protected and there will be consultation with staff associations as the reforms proceed.

## **2.3 Regulatory Building Blocks**

It is vital that the future UHI system operates within a robust regulatory framework. There are two major dimensions to this framework reflecting:

- Regulation of Healthcare Providers
- Regulation of Health Insurers

Key initiatives under each of these dimensions are outlined below. In the case of both providers and insurers, the regulatory role of HIQA and the HIA will be strengthened, as required. Both agencies will be given specific extra functions as described later (see 3.3, 3.4 and 4.3).

### **Regulation of Healthcare Providers**

Effective regulation of the safety and quality of health services is essential to protecting the public, particularly in the context of a competitive healthcare market. HIQA has, therefore,

developed '*National Standards for Safer Better Health Care*', which were formally launched in June 2012. The standards provide a national framework for good governance, patient safety and quality of care. They currently apply to all healthcare services (excluding mental health) provided or funded by the HSE.

The standards will be underpinned by a **mandatory licensing system for healthcare providers**. Licensing of healthcare facilities will extend across both public and private healthcare providers, with an initial focus on hospitals and high risk health services in settings other than hospitals. It will be an offence to provide hospital services or high risk health services without a licence. HIQA will be the licensing authority with responsibility for granting and revoking licences, for inspecting against core standards and for imposing sanctions as necessary.

Draft legislation to underpin the new licensing regime is being prepared at present. It is intended to publish the draft general scheme of a Bill and to undertake public consultation, with a view to commencing the new licensing system in Q1 2015.

In addition to new quality standards and licensing legislation, important initiatives are also underway in relation to the roll-out of **national clinical guidelines and programmes**. The shared aim of the national clinical guidelines and programmes is to optimise patient care.

A National Clinical Effectiveness Committee was established in 2010 to provide a structure for national endorsement of clinical guidelines and clinical audit. National clinical guidelines will provide explicit and transparent guidance for the delivery of safe, high quality and cost-effective care. They will supersede all previous guidelines on a topic and will be utilised across the public and private healthcare system. On 18<sup>th</sup> February 2013, the Minister launched the first National Clinical Guideline – the National Early Warning Score for Ireland (NEWS) – which is now being implemented in all acute hospitals in Ireland.

Alongside the introduction of National Clinical Guidelines, the HSE is currently in the process of developing and rolling out National Clinical Programmes which provide a national, strategic, standardised and coordinated approach to a wide range of clinical services. There are currently over 30 clinical programmes at various stages of development or implementation which aim to improve quality of care, access to services and cost effectiveness.

### **Economic Regulation of Healthcare Providers**

With the introduction of a competitive, purchaser/provider split, it is important to regulate healthcare providers, not only from a quality and safety standpoint, but also from the perspective of governance and financial viability. This is key to ensuring the long-term sustainability of healthcare providers and their ongoing availability for the communities they serve. In order to inform policy development in this area, the Department asked the Health Research Board to undertake an international review of evidence and experience in a range of other jurisdictions.

The experience of England is explored in-depth in the review as it is particularly helpful in considering the regulatory path required to support the transition to independent Hospital Trusts. In England, there is a clear process for transforming state-owned assets into independent legal entities and then governing those entities. This process includes: establishment legislation, preparation and application; assessment and evaluation (against minimum standards); authorisation and licensing for successful entities; quarterly monitoring for breach of licence; and remedies and failure. The governance principles for independent entities follow those recommended by the OECD, with regulation considered an essential underpinning to ensure *accountable* governance. Finally, a noteworthy finding of the review is that, while initial performance indicators in England concentrated on measuring corporate and financial governance, recent initiatives have seen the introduction of new *clinical* governance indicators. This reflects a policy response to a number of high profile cases which highlighted inadequate clinical care.

The review is currently being considered by the Department and should support the development of a healthcare economic regulatory function to underpin the process of transitioning from Hospital Groups to independent Hospital Trusts in a safe, quality assured, economically viable, integrated and sustainable manner.

## Regulation of Health Insurers

Healthcare is an area where competition and markets must be regulated in order to protect the general good. This is particularly true in the case of health insurance markets.

The current private health insurance market is already regulated in accordance with the core principles of **open enrolment, lifetime cover, minimum benefit and community rating**, and is subject to oversight by an independent industry regulator, the **Health Insurance Authority (HIA)**.

Community-rated health insurance systems across the world use risk equalisation as a mechanism to distribute fairly some of the differences that arise in insurers' costs due to the differing health status of all their customers. The introduction from 1 January 2013, of a new **permanent risk equalisation scheme (RES)** in primary legislation (the Health Insurance (Amendment) Act 2012), is a critical plank to maintaining a healthy and functioning voluntary private health market whereby access to private health insurance cover is available to all persons regardless of age or risk profile. The recently enacted Health Insurance (Amendment) Act 2013 provides for (i) revised rates for Risk Equalisation credits and corresponding stamp duty to apply for 2014 and (ii) some technical amendments to the Health Insurance Acts 1994-2012.

The Government's policy objective is to further develop the risk equalisation scheme so that it continues to be as effective as possible in terms of providing the necessary support to community rating while at the same time the scheme remains robust, transparent, and



promotes fair and open competition. The Minister also seeks to maintain the sustainability of the PHI market and, as required under the EU approval to the RES for the period, 2013-2015, ensure that there is no over-compensation of any insurer from the scheme. The Minister has also published a roadmap for the future development of risk equalisation for the period, 2014-2016. During this period the Minister is committed to maintaining the current level of effectiveness of the scheme and, where possible, increasing its effectiveness in relation to those who need the supports most i.e. those aged 70 and over. In addition a more refined measure of health status will be developed.

## **Addressing the Future Status of the VHI**

Under the current regulatory framework for the private health insurance market, the VHI enjoys a derogation from the EU Non-Life Directives which exempts it from the requirement to be authorised by the Central Bank. However, in 2011, the European Court of Justice ruled that, by exempting the VHI from such regulatory requirements, Ireland had failed to fulfil its obligations under the EU Non-Life Directives.

The Government has committed to addressing the European Court of Justice ruling in full by 31st December 2014. To this end, it has agreed that the ongoing work to prepare an application for authorisation of VHI by the Central Bank should be completed as soon as possible. A decision on whether to authorise the VHI will be taken independently by the Central Bank. The Government is committed to retaining the VHI in public ownership in order to provide a publicly-owned health insurer within the new system of UHI.

The Department of Health will continue to work with the VHI, the Central Bank and the EU Commission in order to achieve authorisation by end-2014. In terms of capitalisation requirements for solvency purposes, VHI will seek to self-fund any capital requirements, meaning that no Exchequer funding would be required. Its readiness for authorisation and any subsequent capital requirements will be determined by the by the Central Bank after its assessment of VHI's application for authorisation. If Exchequer funding were required, this would have to be the subject of a separate Government decision and would also have to be approved by the EU under State Aid rules.

## **New Regulatory Functions under UHI**

The above building blocks are necessary to prepare both the purchaser and the provider markets *in advance of* the ultimate move to UHI. However, there are also a range of new regulatory structures and processes which will be required in the future UHI landscape and which must be introduced *at the same time* as introducing UHI. As these new regulatory functions are intrinsically linked with the specific model of UHI for Ireland, they are outlined and explained in Chapter 3.

## 2.4 Financial Building Blocks

The move to an insurance-based health system also requires radical transformation of our existing financial systems. In short, it involves shifting from global budgets to more efficient Money Follows the Patient payment mechanisms, standardising payment systems across public and private patients, and returning the Vote to the Department in order to allow for the dissolution of the HSE and the introduction of a multi-payer health system. Moreover, the reform of our healthcare system must be undertaken against a backdrop of declining resources and increasing demand. This underscores the need to reduce the underlying cost base of the health system so as to maintain the provision of quality services and support affordability as we transition to UHI. Accordingly, a range of financial reform and cost reduction initiatives are ongoing, the most significant of which are described below.

### Return of the Vote to the Department

As part of the reconfiguration of health services, the Vote of the HSE will be disestablished and funding for services will be provided through the Vote of the Office of the Minister for Health with effect from the 1<sup>st</sup> January 2015. The transfer of the Vote requires significant preparatory work, including strengthening the financial control and planning capacity of the Department, and enacting legislation to provide for a new statutory financial governance framework. The drafting of necessary legislation is at a very advanced stage with the Office of the Parliamentary Counsel.

### Introduction of a Comprehensive Financial Management System and Programme Based Budgeting

As acknowledged in *Future Health*, the existing financial and service information systems of the health service are not fit for purpose. This is a particular challenge within the HSE, where financial and service information systems are multiple, fragmented and not fully automated, thereby demanding significant manual intervention in order to produce monthly management accounts, financial statements and the appropriation account. This undermines timely financial monitoring and financial control of our current health system, as well as hampering our ability to cost and plan the transition to UHI.

In 2012, a *Review of Financial Management Systems in the HSE* was undertaken, resulting in wide-ranging recommendations and a commitment to developing a single, comprehensive and enterprise-wide financial management system as a matter of priority. On foot of this review, a Finance Reform Board was established comprising senior representatives from the Department of Health, the HSE and the Department of Public Expenditure and Reform. The Board endorsed proposals for the development and roll out of a comprehensive, unified financial management system and the HSE is currently finalising the business case for submission to the Department of Public Expenditure and Reform.

Aligned with the commitment to a comprehensive financial management system, there is a need to move to programme-based budgeting and reporting of expenditure. This is a crucial



underpinning for the work of the newly established directorates in terms of identifying clear budgets or ‘funds’ and allocating resources on the basis of robust performance contracts and Money Follows the Patient payment systems. Programme based budgeting was further developed in the Health Vote in 2013 within the limitations of the existing financial systems. Further progress on programme based budgeting will be driven and overseen by the HSE System Reform Group.

## Money Follows the Patient

Successful transformation of our services requires a corresponding transformation of our funding model. Payment mechanisms must be designed so that they create the correct incentives and encourage treatment at the lowest level of complexity that is safe, timely, efficient and as close to home as possible.

In February 2013, the Minister published a new *Money Follows the Patient Funding Policy*. While focusing initially on hospital care, the policy sets out a clear vision of a payment system which will drive value-based purchasing and which will continuously evolve to allow money to follow patients *out* of hospital settings and towards the provision of safe, timely care in primary and community settings.

Following a successful consultation process, preparations for the roll-out of the new funding model have been ongoing. These preparations have involved:

- The engagement of an international expert to undertake a high level “State of Readiness” review of the system’s capacity to roll-out Money Follows the Patient (MFTP) in public hospitals;
- The appointment of National Pricing, Commissioning and Finance leads within the HSE to drive the operation of MFTP;
- The establishment of a MFTP Oversight Group chaired by the Department of Health
- The establishment of the Healthcare Pricing Office on an administrative basis from 2014, and
- Roll-out of a shadow funding exercise in 2013 to facilitate systematic comparison of (a) actual hospital activity against baseline activity targets and (b) hospital expenditure against Diagnosis-Related Group (or DRG) prices.

Phased implementation of MFTP commenced on schedule in January 2014. It will initially apply to all inpatient and daycase activity provided in those public hospitals which previously participated in the National Casemix Programme.

Finally, as noted above, future development of funding systems will involve systematically working to standardise payment mechanisms for public and private patients.

## Cost Reduction and Efficiency Initiatives

As a result of the economic and financial crisis, the Irish health system is experiencing unprecedented reductions in public spending. Current expenditure on healthcare fell by 10% between 2009 and 2013 and will reduce by a further €361m or 3% in 2014. Reductions to the health budget are compounded by underlying cost pressures, including substantial population growth and rising incidence of chronic disease.

In addressing the above financial challenges, the Government's focus is on actions that enhance efficiency, secure sustainability and do not compromise the overall goals of the health system. Consistent with this focus, various cost saving measures have included reductions in:

- the public sector pay bill;
- the fees paid to professionals;
- payments to pharmaceutical companies, and
- the number of health workers.

Some of these measures are briefly described below.

### Financial Emergency Measures in the Public Interest (FEMPI) Act 2009

Reductions in fees paid to GPs and other healthcare professionals under the Act have yielded savings of €317m to date with a further saving of €37m due to be delivered in 2014.

### Pharmaceuticals

Price reductions of the order of 30% have been achieved between 2009 and 2013 and important agreements with the Irish Pharmaceutical Association and the Association of Pharmaceutical Manufacturers in Ireland will continue to deliver savings in 2014 and thereafter. In addition, the *Health (Pricing and Supply of Medical Goods) Act 2013*, which came into operation on the 24th of June 2013, introduces a system of generic substitution and reference pricing which will promote ongoing price competition among suppliers, resulting in further savings for both taxpayers and patients. Generic substitution will be introduced incrementally, with the Irish Medicines Board prioritising those medicines which will achieve the greatest savings for patients and the State<sup>20</sup>.

### Value for Money

Significant cost reductions have been achieved through various Value for Money initiatives. In the period, 2007 to 2010, some €680 million in cost reductions were achieved against a target of €500 million under the Value for Money Programme while, in 2011, savings in the order of €740 million were achieved. The Department and the HSE will continue to seek to reduce costs in ways which do not impact on frontline services.

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<sup>20</sup> Reference pricing involves the setting of a common reimbursement price, or reference price, for a group of interchangeable medicines. Reference prices will ensure that generic prices in Ireland will fall towards European norms.

### **Public Service Agreements**

Cost reduction initiatives have focused on both public sector pay and public sector numbers. In addition to pay cuts, overall staffing levels within the public health sector have reduced by nearly 10% since 2007 (based on whole time equivalents). The Public Service Agreements (Croke Park Agreement and Haddington Road Agreement) have been critical in facilitating the continuation of service delivery and the introduction of new and more innovative models of care against a backdrop of cumulative budget and staffing reductions. Further savings and efficiencies will be realised in 2014 through the continued implementation of the Haddington Road Agreement and related initiatives<sup>21</sup>.

### **Special Delivery Unit**

Achieving greater efficiency in terms of faster and fairer access to public hospital care is a key priority of the health reform programme and a prerequisite for preparing the health system for UHI.

The Special Delivery Unit was established in the Department in 2011 in order to drive down waiting times for both scheduled and unscheduled care in Irish hospitals and to introduce a major upgrade in the performance capabilities of the Irish health system. In the case of unscheduled care, there was an overall reduction of 13.4% in the number of patients waiting on trolleys<sup>22</sup> during 2013, which is a reduction of 33.8% compared to 2011. Scheduled care targets remain a challenge but there are recent signs of improvement. 99.99% of adult patients on the Inpatient/Day Care waiting list are waiting less than 8 months. 95% of children waiting for inpatient or day-case surgery are waiting under 20 weeks. 99% of patients waiting for routine endoscopy procedures are waiting less than 13 weeks. Outpatient appointments have reduced by 25% from 399,951 to 300,381 with 98% of outpatients waiting less than 12 months.

### **Private Health Insurance Costs**

The Minister for Health established the Consultative Forum on Health Insurance in early 2012 with a view to generating ideas which would help address health insurance costs whilst always respecting the requirements of competition law. It comprises representatives from the country's main health insurance companies, the HIA and the Department of Health.

In mid-2013, the Minister appointed an Independent Chair, as part of the Consultative Forum, to work with insurance companies and the Department to effect real cost reductions in the private health insurance market. The Minister wants all insurers to address the base cost of their claims and to see all procedures provided in an appropriate, safe healthcare setting, which also provides value for money for consumers. The Chairperson's first-phase report was

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<sup>21</sup> An Incentivised Career Break Scheme was rolled out in the HSE in 2013, while a targeted Voluntary Redundancy Scheme for the HSE and organisations funded by the HSE has also been approved and will be implemented on a rolling basis.

<sup>22</sup> Figure as reported by the INMO on the 27<sup>th</sup> December 2013.

published in December 2013 and a Phase 2 report will be prepared within three months. The Independent Chair has already started discussions on implementation of Phase 1 with all parties involved, the great majority of which will be progressed during 2014.

## **2.5 Information Building Blocks**

High calibre health information will be the lifeblood of the future UHI system. Under a competitive, multi-payer model, information will represent, not only a critical commodity for all actors in the system, but also a critical tool for effective regulation of that system. It is also central to delivering responsive, integrated care across multiple settings. Thus, some of the key building blocks for achieving a high performing future health system include:

- ✓ strong health information governance;
- ✓ standardised, high quality health information datasets;
- ✓ mandatory reporting requirements;
- ✓ central data repositories, and
- ✓ effective, interoperable IT systems.

Several key initiatives are currently being advanced in order to deliver these building blocks.

### **National Health Information Leadership**

As noted, in moving to a multi-payer system, a key issue will be to ensure that the State retains access to comprehensive national demographic, clinical and cost datasets so as to inform policy and planning within the Irish health system. This is recognised in the Government's *Money Follows the Patient Policy* which identifies a requirement for a national information and pricing function. It is also reflected in the Government's recent approval for the recruitment of a Chief Information Officer whose remit will be to ensure that the necessary information, technical and governance infrastructure is in place to facilitate and enable the complex use of client-based data required to achieve health reforms. The Chief Information Officer will be supported by an appropriate team with responsibility for ensuring a comprehensive and systematic approach to health system information requirements as well as ensuring that those information requirements are enabled by ICT solutions.

### **An e-Health Strategy for Ireland**

A key starting point for work on health information systems is the development of an overarching strategy. An e-Health Strategy for Ireland was approved by Government in October 2013.

The strategy identifies opportunities for both the health system and wider economy given the strong base that Ireland enjoys in the ICT, pharmaceutical and medical devices industries and focuses on three key areas:

- supporting patient-driven health care services to supplement and extend traditional health care delivery models and empower patient self-care;
- providing for increased levels of information flow, transparency, customisation, collaboration, and patient choice and responsibility-taking, and
- demonstrating the potential to both improve ‘traditional’ health care systems and also expand the concept of health care through new services.

The Department is currently working closely with the HSE and HIQA in developing the necessary infrastructure and information standards to support implementation of the strategy. This includes the development of legislation enabling the introduction and use of **unique individual health identifiers and unique healthcare provider identifiers** throughout the health system (public and private). Identifiers are integral to reducing the risk of error in patient identification and essential for the introduction of UHI. The Health Identifiers Bill 2013, providing for identifiers, was published in December 2013.

In addition to the Health Identifiers Bill, a separate **Health Information Bill** is being prepared which will establish an overall legislative framework for better governance of health information. This framework will strengthen patients' rights as regards their personal health information and facilitate, with due regard to privacy, confidentiality and security, use of patient information for desirable health service objectives that benefit both the individual and the health system as a whole. For example, the use of patient information to build population health registries represents a means of improving the quality and cost effectiveness of care by applying a population perspective to identifying and addressing health problems. In Sweden such registries have been associated with major improvements in health outcomes. Sweden has the best healthcare outcomes in Europe, even while its healthcare costs hover around the European average of 9% of GDP. Indeed, in 2011, its Government declared the expansion of Sweden's network of registries a national priority and committed to substantially increasing investment in this area on the basis that such investment would reduce growth in overall healthcare spending.

## 2.6 Conclusion

The wide-ranging initiatives described in this chapter represent critical building blocks on the path to UHI. However, they also represent very important reforms in their own right, each of which will drive efficiencies and bring benefits in advance of the introduction of an insurance-based health system. As mentioned at the beginning of this chapter, these initiatives will combine to form a bridge to the future UHI system. The next three chapters look ahead to that ultimate destination and provide further insights in relation to the future UHI landscape.

## **3. A Universal Health Insurance Model for Ireland**

### **3.1 Introduction**

The Government has set out a far-reaching policy vision for the Irish health service. It is a vision of a single-tier health service which promotes health and wellbeing, provides equal access based on need rather than ability to pay and delivers true value for Irish citizens. The ultimate realisation of this vision will be achieved through universal health insurance.

The transformation to a system of UHI raises many fundamental policy questions. First and foremost among these questions is what model of UHI should Ireland introduce.

In order to answer this question, the Department of Health reviewed multi-payer models across many jurisdictions, having regard to the policy set out in the Programme for Government. This review led to consideration of a number of multi-payer models which were then subject to intensive and in-depth policy and legal appraisal. On foot of this work, the Government has decided on a model of UHI which it believes best fits the Irish system and meets the needs of the Irish public and reflects the requirements of the Programme for Government. This model is described in detail below.

### **3.2 Overview of the UHI Model for Ireland**

#### **Summary of Model**

Under the future model of UHI, every member of the population will be insured for the same comprehensive package of healthcare services. People will purchase insurance for this standard package from one of a number of competing health insurers. This model of managed competition will include commercial ‘for profit’ health insurers as well as the option of a State-owned, ‘not for profit’ VHI.

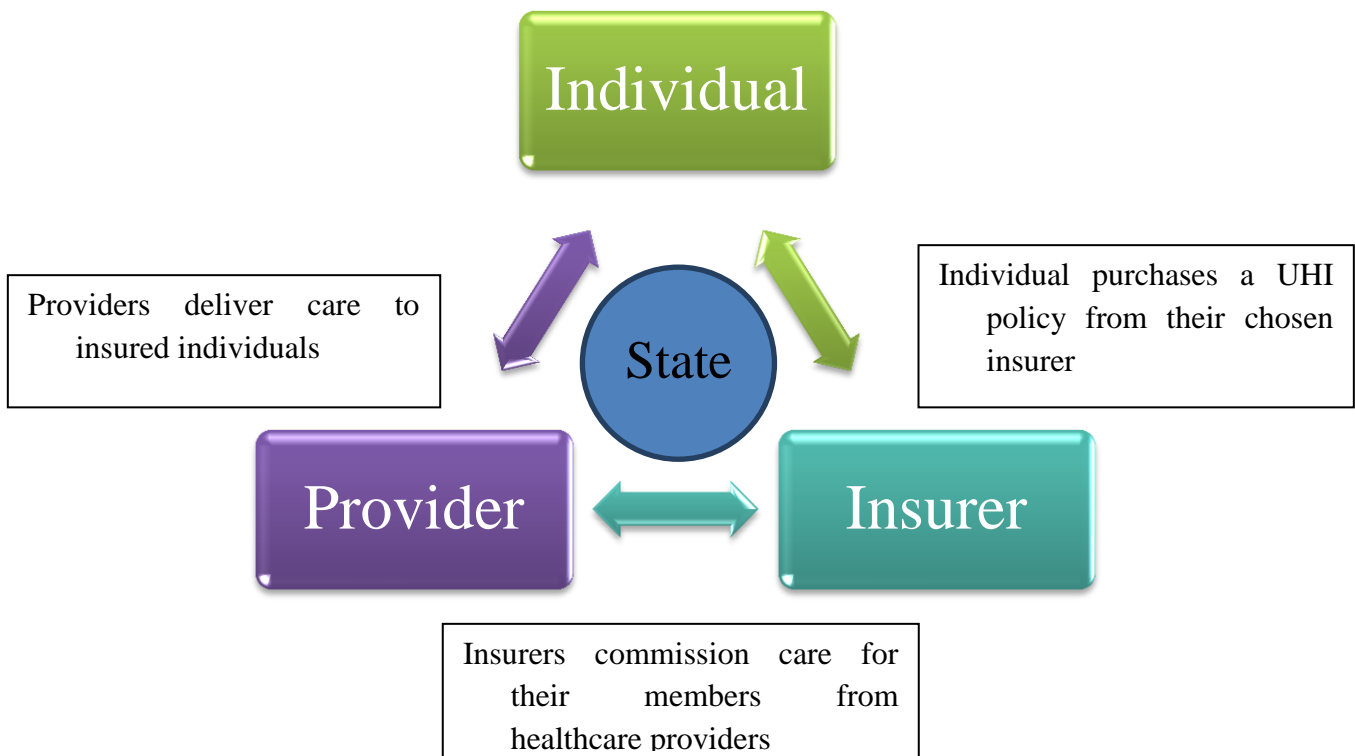
The UHI system will be founded on principles of social solidarity encompassing the fundamental tenets of financial protection, open enrolment, lifetime cover and community rating. A system of financial support will ensure affordability by directly paying or subsidising the cost of insurance premiums for all those who qualify.

Health insurers will purchase care for their members from primary care providers, independent not-for-profit Hospital Trusts and private hospitals. In line with the fundamental principle of social solidarity, neither insurers nor providers operating within the UHI system will be allowed to sell faster access to services covered by the UHI standard package of care.

Finally, the State will retain a central role within the future UHI system, providing financial support towards the cost of UHI premiums and regulating the behaviour of all parties.

The UHI model is summarised diagrammatically in figure 3.1 below, while further details on each aspect of the model are provided in subsequent sections.

[Figure 3.1: Summary Overview of UHI Model](#)



### Buying a Universal Health Insurance Policy

Under UHI, everyone will be required to purchase a universal health insurance policy ('UHI policy') providing cover for a standard package of healthcare services. In purchasing a UHI policy, everyone will have a choice between competing insurers. To help people in making this choice, each insurer will be required to publish full details of the standard package of healthcare services, including both the premium which each will charge for this standard level of cover and any co-payments which may apply. The HIA will also provide independent information and comparison of different UHI policies.

Every UHI policy will be subject to a uniform set of policy terms and conditions set down in law. In addition, people will enjoy the following important protections when purchasing a UHI policy:

- ❖ **Open enrolment:** A person must be accepted and provided with a UHI policy by their chosen insurer regardless of their age, health status or other risk factors.



- ❖ **Lifetime cover:** Every person will have the right to renew their UHI policy regardless of their age, health status or other risk factors.
- ❖ **Community rating:** Insurers will not be allowed to charge different premiums for the same policy depending on an individual's risk profile ('same policy, same premium'). This principle of community rating will be supported by a system of risk equalisation.
- ❖ **Equal access:** Insurers will not be allowed to sell a policy conferring faster access to services covered by the standard UHI package, i.e. all policies must adhere to the fundamental principle set out in the Programme for Government of access based on need.

People will pay their insurance premium directly to their chosen insurer and will have the right to switch insurer annually. However, where a person is unable to afford UHI cover, they may apply for financial support (see below).

Finally, where a person fails to purchase a UHI policy, the State will purchase a policy on their behalf (i.e. 'cover of last resort'). This could arise for a variety of reasons such as a person refusing to take out insurance cover, allowing their cover to lapse or lacking the capacity to enter into an insurance contract<sup>23</sup>. In such cases, the State, having followed due process, will select an insurer on the person's behalf and will pay the premium directly to that insurer. It will then recoup the cost of the premium at source, where appropriate, from the individual's earnings or benefits.

## Applying for Financial Support

The State will pay or subsidise UHI policy premiums for all those who qualify on income grounds. Responsibility for managing this financial support system will reside with the National Insurance Fund situated within the Healthcare Commissioning Agency.

Where a person believes that they qualify for a means tested financial support, they will make an application to the National Insurance Fund. The Fund will undertake a financial assessment of the person's means and will determine whether the person qualifies for financial support and, if so, the amount of financial support to which they are entitled. The financial support system will be designed in a manner that will ensure that entitlement will not become a disincentive to entering or remaining in the labour market.

In determining the maximum amount of financial support payable, the Fund will have regard to an overall monetary threshold called the 'efficient market rate'. The 'efficient market rate' refers to a reasonable UHI policy premium offered by an average efficient insurer. The value of the 'efficient market rate' will represent the maximum value of financial support payable towards the cost of a UHI policy premium.

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<sup>23</sup> Where a person lacks the capacity to contract, then the State would only purchase cover on the person's behalf in cases where no formal attorney or guardian exists.



The 'efficient market rate' fulfils a very important dual role under UHI: firstly, it protects those on low incomes and, secondly, it protects the taxpayer by stipulating a maximum monetary threshold which the State may pay. As such, it is key to supporting the underlying policy goals of financial protection, equity and financial sustainability.

Once the Fund has completed a financial assessment, it will notify the person of the outcome of their application. If the person qualifies for means tested financial support, the Fund will ask them to confirm details of their chosen insurer and their chosen UHI policy. The Fund will then pay the financial support directly to the person's preferred insurer on their behalf. The person will be required to pay the balance of cost of the UHI policy premium where applicable (for example, if the person qualified for a subsidy of €800 and the UHI policy premium amounted to €1,000, then the person would be liable for the balance of €200 and would pay this directly to the insurer).

## **Buying Supplementary Health Insurance**

UHI represents a fundamental change to our current system of health insurance. Currently, insurance policies provide cover for health care provided in a particular setting e.g. a private or semi-private room. Under UHI, health care will not be provided with reference to a particular setting, rather the standard package will cover health care - which much meet certain standards e.g. in relation to quality and safety – irrespective of the setting in which it is provided. It is worth noting however that the standard in modern health care provision is towards provision of single room accommodation rather than wards.

It will be open to individuals to purchase cover for their care to be provided in particular settings e.g. with satellite TV, or other such facilities. These non-health care related services will not be community rated, but because these are not related to the provision of health care, there is no particular reason why they should be risk rated.

Individuals may also wish to purchase insurance cover for health care not included in the UHI basket, for example, purely cosmetic surgery, or alternative therapies. As these services are neither included in the standard UHI basket of services, nor included in the range of health care that will continue to be provided directly by the State e.g. social and community based care, this additional cover would not be community rated.

However, people will still enjoy the protection of the legal principles of open enrolment and lifetime cover when purchasing supplementary insurance. In other words, a person must be accepted by their chosen insurer and has the right to renew their policy, albeit that their premium can be actuarially priced based on age, health status or other risk factors.

Moreover, where a person purchases supplementary insurance, this must be provided separately and may not be 'tied' to the UHI policy, i.e. a person can purchase supplementary insurance from a different insurer than the one with whom they have their UHI policy and

cannot lose coverage for supplemental items by reason of switching insurer for the standard UHI package or vice versa. Finally, as with standard UHI policies, no insurer may sell a supplementary health insurance policy conferring faster access to services covered by the standard package of care.

## **Obtaining Healthcare**

The introduction of UHI will see the purchasing of primary and hospital care largely devolved to insurers. Health insurers will commission care for their customers from primary care providers, independent not-for-profit Hospital Trusts and private hospitals.

In commissioning care, each insurer must provide cover for the full standard UHI package of services and must comply with any quality and geographic coverage rules set down in law. Once such rules are met, insurers are free to engage in selective contracting of healthcare providers. This will allow insurers, within clear limitations, to offer different types of UHI policies offering a greater or lesser choice of healthcare providers and with differing levels of excess.

In terms of obtaining care, a person will be insured and entitled to receive all services covered by the standard UHI package from the date of purchasing their UHI policy. As UHI insurance cover is universal and mandatory, there will be no waiting periods for pre-existing conditions. By law, insurers will be required to provide mandatory cover for the standard UHI package and, therefore, insurers will not be able to avoid payment for a claim based on non-disclosure or misrepresentation of a pre-existing condition in a proposal form.

Notwithstanding the above protections and the role of the State in purchasing ‘cover of last resort’, situations may arise from time to time where uninsured persons require necessary emergency healthcare. In such circumstances, healthcare providers will be able to apply to a statutory fund (the ‘Compensation Fund’) for reimbursement of relevant healthcare costs. The Compensation Fund will be financed via a levy on all health insurers operating in the Irish market and will also have the power to pursue uninsured individuals in respect of their outstanding healthcare costs.

## **3.3 Regulatory and Administrative Structures**

The future model of UHI involves a sea-change in the role of the State. In essence, this change will see the State shift from direct financing and delivery of health services to regulation and oversight of a competitive system of purchasers and providers. Put more succinctly, it will involve a substantial shift from rowing to steering. As the overall steward of the new UHI system, the State will fulfil several important regulatory and administrative roles relating to:



A very brief description of each of these roles is set out below.

### **Regulation of the Standard Package of Services**

In order to guarantee social solidarity and social protection, it is vital that all members of society are covered for the same core set of health services, namely the standard UHI package. In a multi-payer environment, it is also necessary to have a single authority responsible for defining that standard package, for mandating changes to it and for adjudicating on disputes in relation to it. The State will, therefore, have a key role in determining the standard UHI package; including regulating the minimum and maximum out of pocket payments which may be applied as part of that standard package. This is discussed further in chapter 4.

Aligned with the issue of determining service coverage, the State will also have a role in relation to implementing the EU Directive on Patients' Rights in Cross-Border Healthcare. The Directive essentially entitles people to reimbursement for care received in another EU Member State in cases where that care is covered by the person's own national health system. While prior authorisation may apply for certain types of care, Member States must publish details of which healthcare services are subject to prior authorisation and must operate an objective, non-discriminatory and easily accessible system of prior authorisation. This requirement for a standardised, equitable approach to authorisation highlights the need for a single, national authority tasked with managing the system of prior authorisations on behalf of all health insurers (see chapter 4).

## **Regulation of Financial Support and Population Coverage**

As noted above, the State will pay or subsidise UHI policy premiums for all those who qualify on income grounds. In order to do this, the State, through the National Insurance Fund, will firstly need to undertake financial assessments to determine entitlement to means-tested financial support and will then need to manage the payment of financial support to each individual's preferred insurer, including managing the redirection of financial support payments where a person switches insurer.

Related to the payment of financial support, the independent regulator for the insurance industry, the HIA, will have a role in recommending the 'efficient market rate', above which the State will not pay financial support. Determining the efficient market rate requires rigorous analysis of detailed market data and the subsequent calculation of a reasonable UHI policy premium based on an average, efficient insurer. The 'efficient market rate' must be calculated fairly so that it is representative of the relevant costs of the average 'efficient' insurer. Moreover, both the 'efficient market rate' and the underlying formula for calculating the rate will be reviewed annually so that they continuously take account of healthcare inflation and other cost pressures or trends.

Finally, a further role for the State under this domain relates to purchasing UHI policies on behalf of all those who fail to take out cover (purchasing 'cover of last resort'). This will involve (i) establishing, through an objective procurement process, a panel of health insurers willing to provide cover of last resort, (ii) monitoring individual compliance with the UHI system, (iii) notifying uninsured individuals of their obligations under UHI and providing them with an opportunity to purchase cover of their choice, (iv) where a person still fails to obtain a UHI policy, purchasing cover of last resort on the person's behalf from one of the insurers on the panel (a process which will require a fair and transparent system for assigning individuals to different insurers on the panel), and (v) recouping the cost of UHI premiums at source from a person's earnings or benefits in cases where last resort cover is provided.

## **Regulation of the Health Insurance Market**

Regulation of the health insurance market is vital to achieving social protection goals and ensuring that the market operates to the benefit of the general good. As noted, the market is already overseen by an independent regulator, the HIA. Under UHI, the HIA will retain a central role in terms of general regulation of the market. This will entail:

- i) monitoring the behaviour of all insurers to establish compliance with all governing legislation and with the principles and statutory requirements set out therein (e.g. overseeing adherence to standard UHI policy terms and conditions, i.e. the 'standard plan' and to principles of open enrolment, lifetime cover, etc.);
- ii) deploying sanctions where an insurer breaches legal requirements;

- iii) gathering and analysing detailed market data from health insurers to support the effective discharge of regulatory functions, particularly in relation to risk equalisation and cost control;
- iv) providing independent and impartial information to the public regarding their consumer rights and different UHI policy options, and
- v) managing a public complaints process in relation to the health insurance market.

The Central Bank also has a regulatory role in relation to the current private health insurance market. Under the Government's preferred model of UHI, this role will continue and all insurers, including the publicly-owned VHI, will be required to be authorised as insurance undertakings and to hold sufficient capital reserves.

Furthermore, the community-rated UHI market will be underpinned by a scheme of risk equalisation. As noted in chapter 2, the Minister has developed a roadmap for the future development of risk equalisation which will allow for more refined health status measures within the scheme. This will be critical to providing the necessary support to community rating under UHI but will also demand more comprehensive and sophisticated data collection and analysis.

In addition to general oversight of the market and management of risk equalisation, a third major task in relation to regulation of the health insurance industry will involve managing a fund to meet the costs associated with insurer insolvency ('Insolvency Fund'). Consistent with the recent approach adopted in relation to the Quinn Insurance Group, the Insolvency Fund will levy a charge on all UHI policies but this charge will not materialise until such time, if ever, that an insurer is rendered insolvent.

Finally, effective cost control will be absolutely critical to the affordability and sustainability of the future UHI system. As such, a very specific and significant regulatory function under UHI will be the management of cost control mechanisms within the health insurance market. Details of the planned cost control mechanisms to be put in place are set out in section 3.4 below.

## **Regulation of the Healthcare Provider Market**

As highlighted in chapter 2, the State will regulate the quality and safety of all healthcare providers via National Standards underpinned by a statutory licensing regime. It will also establish economic regulation mechanisms designed to safeguard good governance and financial management of health services. In exceptional circumstances, this regulatory role could extend to intervening in order to rescue a healthcare provider who is critical to meeting population health needs (i.e. who is providing an essential service of general economic interest).

In addition to the above functions, new regulatory structures will be required to underpin the fundamental principle of equal access based on need. This will demand the introduction of new oversight arrangements, whereby the waiting lists of all providers operating within the UHI system will be subject to continuous monitoring and sanctions will be applied where equitable and transparent access arrangements are breached. In other words, this function will require an expansion and strengthening of the oversight work currently undertaken by the Special Delivery Unit (SDU). It must be emphasised that, within the overall regulatory framework for UHI, this particular function is most critically connected to achieving the goal of a single-tier system.

Finally, in advance of introducing UHI, the State will review the notification thresholds enshrined in merger control law to ensure that they are consistent with requirements for supporting a competitive healthcare market. This will be with a view to certifying that transactions involving mergers of healthcare providers are captured by the process where appropriate and can be examined in relation to their impact on competition.

## **Management of Contractual Disputes**

In addition to regulating the individual purchaser and provider sectors, it is also necessary to manage the interface between the two. This is important in order to protect continuity of service provision for users. Accordingly, the State will establish new statutory processes to support practical and timely resolution of disputes between insurers and healthcare providers in circumstances where:-

- contract negotiations between insurers and healthcare providers break down, or
- disagreements arise in relation to the interpretation and operation of existing contracts between insurers and healthcare providers.

Such processes will have regard to independent arbitration and adjudication in the first instance.

## **Central Management of Information and Healthcare Costs**

Two final roles for the State will involve the central management of national health information systems and central control of certain healthcare costs. Each of these is reviewed in brief below.

### **Management of National Health Information Systems**

Information will be at the heart of the UHI system. It is the fuel that will drive:

- ✓ UHI insurance contracts between citizens and insurers,
- ✓ healthcare commissioning arrangements between insurers and providers,
- ✓ financial support systems for those who are unable to meet the cost of UHI premiums,
- ✓ safe and effective service delivery by healthcare providers and, above all,
- ✓ effective regulation of the overall system.

Quite simply, every aspect of the UHI regulatory framework is critically dependent upon timely, high quality information. While this is true of any healthcare system, it is particularly important in a decentralised model where information is dispersed across multiple purchasers and providers. Such a health system must be subject to a robust regulatory regime whereby legal requirements exist to collect and share standardised information with a designated national authority or authorities using interoperable systems. That information must then be used to support, *inter alia*, national level planning and priority-setting, effective monitoring and oversight of all actors within the system, and the calculation of financial support payments, risk equalisation payments and the ‘efficient market rate’. In other words, it must be used to support overall coherent, integrated management of the healthcare system in the interests of the Irish people.

As noted in chapter 2, various legislative, policy and infrastructural building blocks are being put in place to support effective national information management. Central to this work is an acknowledgement that information has both a value and a cost. In the case of the latter, there is a need to reduce data duplication across the health sector by adhering to the core principle that information should be collected once but then used for multiple purposes within an appropriate governance framework.

Finally, while the emphasis in this section is on information to support better regulation, it is worth emphasising that quality information is needed at every level of the health system. After all, information is what drives integration, not only at national level, but also at the level of caring for the individual patient.

### **Central Cost Management**

The Programme for Government commits the State to managing those costs for which central control is most effective. There are three broad dimensions to this role.

Firstly, the State, via the Healthcare Commissioning Agency, will continue to directly finance those service programme areas which remain outside the UHI system. Secondly, even where service programme areas come within the scope of the multi-payer UHI system, it may make sense for the State to centrally finance certain specific services. For example, while the UHI system will cover hospital care, there may be potential efficiencies to be gained from the State funding ambulance, emergency department and certain national speciality costs on a central basis. Both of these issues are considered further in chapter 4.

The third dimension to the State’s central funding role relates to the management of a Compensation Fund to meet the healthcare costs of the uninsured. These costs are likely to arise where an uninsured individual suddenly requires necessary emergency treatment and could place a very substantial financial burden on the healthcare provider who ends up providing this emergency treatment.



In the same way that it is considered unfair that any one individual would bear the costs of being injured by an uninsured driver, similarly, it would be unfair for an individual healthcare provider to have to bear the healthcare costs of an uninsured individual. In the case of uninsured drivers, the Motor Insurers Bureau of Ireland (MIBI) has established a fund which compensates the victims of accidents caused by uninsured drivers. The MIBI Fund is supported by a levy on all policies but also retains powers to pursue uninsured drivers for costs. The Government plans to introduce a similar model for dealing with uninsured healthcare costs, whereby healthcare providers could apply for reimbursement from the statutory Compensation Fund, which would be supported by a levy on all UHI policies and would have the authority to directly pursue uninsured individuals in respect of costs.

### **3.4 Cost Control Mechanisms**

The design and implementation of any new healthcare system will involve certain once-off costs. The Government is determined that total spending by the State on healthcare under a single-tier UHI system should not exceed its total spending under the two-tier system which it replaces. This approach will allow for cost effective additional investment in health services in line with increases that are consistent with our Constitutional and legal obligations under the Treaty on Stability, Coordination and Governance (the Fiscal Compact) and the Stability and Growth Pact, and it will take account of demographic factors as our population ages. The Government, therefore, plans to introduce a comprehensive cost control regulatory framework for the UHI system. This cost control framework will be in two parts.

The first part will comprise a suite of cost control measures which are relatively low intensity and which will be implemented with immediate effect from day one of the new UHI system. These measures are set out in the green section of the table below.

The second part will comprise a range of more intensive measures which will be set down in UHI legislation but which will not be implemented unless required. In other words, they will be held in reserve unless increases in overall health expenditure demand that one or more of them be brought into force. These more intrusive regulatory measures are described in the orange section of the table below.



[Table 3.1: Summary of Cost Control Regulatory Framework](#)

<b>Core Measures</b>	
<i>Cost Control Measure</i>	<i>Brief Description of Measure</i>
<b>1. Stipulation of prescribed payment methods to be used in all UHI commissioning</b>	<p>This will involve the State stipulating the types of payment methods which all insurers must use when negotiating and agreeing contracts with healthcare providers. For example, the State could direct that all hospital services would have to be funded using Diagnostic Related Groups (DRGs) and annual capped contracts, although it would not stipulate actual DRG prices or the level of capped contracts.</p> <p>DRGs are an internationally accepted classification system used for case based payment systems. DRG based payment systems incentivise providers to continually reduce costs, by utilising a more efficient use of resources. The important role for DRGs has been identified in a number of reports in recent times<sup>24</sup></p>
<b>2. Price monitoring of insurers</b>	<p>This will require the regulator to monitor the costs underlying UHI premium prices through (i) ongoing desktop price monitoring, (ii) annual reviews of all insurers, (iii) the issuing of non-binding recommendations to insurers and (iv) the publication of the comparative cost and efficiency levels of each insurer.</p> <p>The monitoring and scrutiny of cost data is critical to ensuring that consumers have the ability to access independent information to inform their purchasing decisions which is a key element of competition. National monitoring of prices will also be important as it can highlight price anomalies which can be an early indication that quality of care is being compromised.</p>
<b>3. Capping of tax relief/ financial subsidy on UHI premiums</b>	<p>This will involve retaining an annual cap on the level of UHI premium for which a person receives standard tax relief/ financial subsidy in order to encourage downward pressure on premium prices.</p>
<b>4. Setting maximum prices for healthcare providers</b>	<p>This mechanism will see the State, i.e. the Minister for Health on the recommendation of the Healthcare Pricing Office, set the maximum prices payable for specific health services. Insurers and providers will be able to negotiate rates below this maximum price but will not be able to exceed it. Maximum prices will be reviewed at regular intervals.</p>

<sup>24</sup> Report of the Expert Group on Resource Allocation and Financing in the Health Sector 2010 and the Review of Measures to Reduce Costs in the Private Health Insurance Market, 2013

<b>Reserve Measures</b>	
<b><i>Cost Control Measure</i></b>	<b><i>Brief Description of Measure</i></b>
<b>5. Capping insurer overhead and profit margins</b>	<p>This involves placing a regulatory price cap on an insurer's overhead costs in the first instance. For example, the State may stipulate a limit on the portion of total premium revenue which may be allocated to insurer overheads such as marketing, claims handling and maintenance of regulatory capital.</p> <p>The Government may consider limiting insurer profit margins in exceptional circumstances should this become necessary.</p> <p>Imposing an expenditure cap on overheads is intended to incentivise administrative efficiency by insurers.</p>
<b>6. Capping insurer claims expenditure</b>	<p>This would involve the regulator setting a maximum level of risk-adjusted health service expenditure per capita in order to control overall health system expenditure. In order to do this, the regulator would implement a separate price control decision for each insurer in the market which would determine the maximum annual expenditure on UHI health services per average person insured based on each insurer's individual risk profile. Each decision would be based on the same, standard underlying process and would be regularly reviewed to take account of switching between insurers, healthcare inflation etc.</p>
<b>7. Setting a global budget cap for each insurer</b>	<p>This regulatory tool is essentially a combination of the previous two mechanisms insofar as it would involve prescribing a maximum expenditure envelope (encompassing all costs) for each health insurer and stipulating that the insurer must remain within that envelope.</p>

Furthermore, while the calculation of the 'efficient market rate' is fundamentally aimed at ensuring that financial support payments guarantee fair and equitable access to the UHI market for those on low incomes, it is intended that it will also apply some downward pressure on UHI premiums, thereby complementing the cost control framework set out in the table above.

Finally, a series of further measures will be introduced over the next few years, prior to the introduction of UHI, which will provide demonstrable evidence of lower costs and enhanced productivity and efficiency in both the public and private health systems. One such measure is the establishment of the Healthcare Pricing Office on an administrative basis on 1 January 2014. This will have an important role in cost control as its work develops. The cost data that it will generate will promote an increasing level of transparency and a greater ability to drive down costs as the source of these costs come into focus. As the Healthcare Pricing Offices develops its functions and data, it will have the ability to set prices with reference to

best practice, thus incentivising providers to deliver care at the lowest level of complexity and cost. In this way, the Office will become a powerful tool to drive greater efficiency and lower costs in the Irish healthcare system.

### **Role of the Regulator**

The successful execution of the above cost control regulatory framework will require a strengthening and expansion of the powers of the HIA. In practical terms, the implementation of the various measures will demand enhanced statutory powers to both compel the submission of detailed market data and apply sanctions where insurers breach regulatory requirements, e.g. exceeding expenditure caps.

This expansion of the HIA's regulatory powers will, in turn, necessitate the development of a new system of accountability by the regulator to the Government. This could include, for example, mechanisms for formal regular reporting to the Minister for Health and the Oireachtas.

# 4. The Future Health Basket

## 4.1 Introduction

Arguably the most important question to be addressed when designing the future health system is what services should be provided by that system. There are two dimensions to this question, namely:

- Ⓢ **what services should be provided on a universal basis and funded via the future universal health insurance system (standard UHI package) and**
- Ⓢ **what services should be provided or funded directly by the State, either on a universal basis or on the basis of clear eligibility criteria.**

When designing the future health system, it is vital to address both dimensions. In other words, it is necessary to think about the overall **health basket** which will encompass both of the above categories of services and will represent the fundamental framework for entitlement to health services in Ireland.

The issue of the health basket is of central importance to all Irish people as both the funders and users of the health service. Indeed, it could be argued that it goes to the heart of the contract that exists between the State and its citizens in relation to healthcare. As such, the Government has identified the following overarching principles which will frame this fundamental contract and ensure that decisions in relation to the health basket are aligned with national health policy goals and with the overall strategic direction of the health service in Ireland:

1. The Irish Government recognises the right of the Irish people to the enjoyment of the highest attainable standard of physical and mental health. In order to support this, the Government will set out in legislation, the entitlement of every person, regardless of personal characteristics and status, to universal coverage for a comprehensive basket of health services and the obligation to contribute to the cost of services, in proportion to ability to pay.
2. In prescribing the basket of health services, the Government recognises health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” As such, it acknowledges that a central role of the health service is to improve the health and wellbeing of people in Ireland.
3. The composition of the health basket should acknowledge and promote the key role of primary care at the heart of the health system. It should also facilitate the delivery of integrated, person-centred care provided at the lowest level of complexity that is safe, timely, efficient and as close to home as possible.
4. The composition of the health basket should reflect a continuous commitment to ensuring that public funds provided by the Irish people are used to optimal effect so that our health service can achieve the best health outcomes for available resources.
5. Services included in the health basket should be safe, effective and of high quality.

In addition to these overarching principles, the Government has also agreed:

- ✓ a process for setting the initial health basket to be provided under the future health system
- ✓ a set of structures and processes for ongoing management of the health basket, and
- ✓ a set of policy proposals in relation to the services which might be covered as part of the standard UHI package

Plans in relation to each of the above are set out in sections 4.2 to 4.4 below.

## 4.2 Initial Process for Establishing the Health Basket

Decisions on the composition of the future health basket are not simple or straightforward. Rather, they are complex and multi-faceted, involving various technical, economic and ethical considerations. Above all, they are deeply value-laden. As such, it is very important that the values underpinning the health basket reflect the values of the society served by that health basket. Indeed, examples cited as good practice in decision-making processes from other jurisdictions involve a critical blend of both technical appraisal *and* comprehensive public engagement via a Citizen Council (National Institute for Health and Care Excellence (NICE), UK) or a Citizen Health Parliament (Israel).

In recognition of this, the Government will ask the Joint Oireachtas Committee on Health and Children to develop a values framework. The work of the Joint Committee will be informed by the illustrative values framework set out below and it will report to the Minister on a final values framework.

The Government also plans to establish a **Commission** which will work in tandem with the **Joint Oireachtas Committee on Health and Children** to engage with the public and with all health system stakeholders and relevant organisations in relation to the composition of the future health basket. The Commission will be tasked with preparing detailed options for consideration by Government on the scope and composition of the future health basket including, in particular, the standard package of services to be covered under UHI. The Commission's membership and terms of reference will be set by the Government; however, the role of the Commission is likely to include

- Applying the values framework as agreed by Government and taking account of the consultation processes, to develop proposals in relation to the future health basket, and specifically:
  - to develop detailed and costed options on the list of services which should be included in the standard UHI package, including any conditions and targeting which should apply in relation to coverage of such services, and
  - to advise on the services which should be funded via the Exchequer but separately to the system of UHI.

Having fulfilled each of these functions, the Commission will submit detailed and costed options for consideration by Government. The Joint Committee will also consider the options as set out by the Commission and will report its views to the Minister. The final decision on the future health basket for Ireland will be made by the Government.

A more in-depth look at the role and function of both the Commission and the Joint Oireachtas Committee is provided below.

## Consultation

As already noted, the decision in relation to the health basket is fundamental to the health service and its users. It is vital that those at the heart of our health system as well as the wider public are included in the debate. Public consultation will, therefore, form the centrepiece of the Government's action plan for setting the health basket. The purpose of the consultation will be twofold -

- to inform the development of a values framework (see below), and
- to obtain views on the scope and composition of the future health basket, including the services which should form part of the standard UHI package.

The consultation process will involve the Joint Oireachtas Committee on Health and Children conducting hearings with well-established health sector organisations and representative groups (e.g. national groups representing patients, healthcare professional organisations, healthcare provider organisations, health insurers, health technology manufacturers and local community groups, as well as bodies representing minorities or marginalised groups such as the homeless). These hearings will in the first instance, focus on the values which should underpin decisions on the composition of the future health basket. In being asked to contribute to the development of a values framework, participants will be asked a set of explicit questions which force deliberation on difficult ethical issues and require hard choices to be made. It is noted that the Israeli parliament used this latter approach to unearth distinct societal values and preferences. The illustrative values framework outlined below is intended to provide a starting point to aid the development process and stimulate collective deliberation and public debate. The Committee will report to the Minister, and Government will make final decisions on the values framework.

The Commission will also undertake a comprehensive consultation process on the costed options for the services to be included in UHI and the wider health basket. The consultation process will be guided by principles of inclusivity, accessibility and diversity. The Commission will develop proposals to facilitate consultation with people who will pay for the health system while perhaps having low involvement in the sector, i.e. the average tax payer. The aim will be to ensure a rich, diverse and informed debate involving, on the one hand, the use of experts to explain and clarify issues for the benefit of all participants and, on the other hand, the use of non-technical language to the greatest extent possible. To ensure a meaningful consultation, the consultation process will be highly structured. Importantly,

participants in the consultation process will be asked to comment on costed policy options, thereby offering a view, not only on the services which they perceive as valuable, but on their willingness to pay for those services. In this way, the difficult trade-offs and opportunity costs which policy-makers have to confront when taking real-life coverage decisions will be explicit and explored in a meaningful way.

Once the Commission has developed a number of costed policy options in relation to the future health basket, and the standard package of care to be provided under UHI, it will forward its finalised costed options to Government. The Joint Committee will also consider the options provided, and will report to the Minister for Health on the final list of costed options to be presented to Government.

### Development of the Values Framework

As highlighted above, service coverage decisions are highly value-laden. It is, therefore, imperative that the shared values of society are understood and underpin decisions in relation to the composition of the future health basket. The consultation process will support the development by the Joint Committee of a values framework which embraces the ethical, economic and technical aspects of coverage decisions and which will be used in assessing health services and technologies.

The framework below is presented by Government as a starting point to aid the development process and stimulate collective deliberation and public debate. It sets out a range of possible values as well as the ethical, economic and technical questions which stand to be addressed when deciding on these values.

[Figure 4.1: Illustrative Value Framework](#)

Possible Value	Issues for consideration & core tensions
<p>Ⓢ <b>Safe</b></p>	<ul style="list-style-type: none"> <li>➤ Is the treatment/ service/ technology safe?</li> <li>➤ Do the risks outweigh the potential benefits under any/ all circumstances?</li> </ul>
<p>Ⓢ <b>Essential</b></p>	<ul style="list-style-type: none"> <li>➤ Is the treatment/ service/ technology essential?</li> <li>➤ Should all life-saving treatments be considered essential or should quality of life and life expectancy be taken into account when considering whether life-saving treatments are essential?</li> <li>➤ Is it necessary for a service to demonstrate substantial health quality gains or years of life gained in order to be considered essential and how do we measure this and balance it against cost?</li> <li>➤ Are services which are palliative rather than curative essential and how do we prioritise between these two different types of services? In addition to concepts of 'life saving' and 'health</li> </ul>

	<p>improving’, should the concept of ‘maintaining human dignity’ be factored into considerations of which services are deemed essential?</p> <ul style="list-style-type: none"> <li>➤ Are services relating to lifestyle choices or religious beliefs (e.g. tattoo removal, circumcision) essential or non-essential?</li> </ul>
<p>Ⓢ <b>Effective</b><sup>25</sup></p>	<ul style="list-style-type: none"> <li>➤ Does the treatment/ service/ technology achieve the desired or intended effect and are there undesirable or unintended side effects or consequences?</li> <li>➤ Are there certain conditions which impact on the effectiveness of the treatment (e.g. only improves outcomes for particular patient groups)?</li> </ul>
<p>Ⓢ <b>Efficient/ Cost-effective</b></p>	<ul style="list-style-type: none"> <li>➤ Is there an existing or alternative treatment/ service/ technology which produces the same outcome at lesser cost?</li> <li>➤ Should there be a test or measurement threshold below which a treatment/ service/ technology is not deemed to be cost-effective (e.g. a QALY threshold)?</li> </ul>
<p>Ⓢ <b>Burden of disease</b></p>	<ul style="list-style-type: none"> <li>➤ Should treatments which have the greatest overall impact on the burden of disease across the total population be prioritised?</li> <li>➤ Should severity of disease be taken into account when assessing treatments and prioritising scarce resources?</li> <li>➤ How do we balance the needs of the many against the needs of the few (e.g. rare diseases versus common conditions)?</li> </ul>
<p>Ⓢ <b>Resource Impact on the Health System and overall Economy</b></p>	<ul style="list-style-type: none"> <li>➤ What is the cost to the health system and to the individual of the particular treatment/ service/ technology?</li> <li>➤ How does the cost of this treatment impact tax rates/ labour costs/ personal incomes/ consumer spending?</li> <li>➤ What is the opportunity cost of a decision to fund this treatment? Could the money be spent to better effect on other health services, other public services or private consumption (i.e. what is the net welfare benefit relative to other policy options)?</li> <li>➤ Is it fair to share this cost at a societal level or should some costs be a matter of personal responsibility?</li> </ul>

<sup>25</sup>Many countries include the criteria ‘efficacy’. The term ‘efficacy’ can sometimes be used interchangeably with ‘effectiveness’. However, the latter term is broader in meaning. For example, a drug’s efficacy is a measure of the ability of the drug to treat whatever condition it is indicated for. It is not a statement about the drug’s tolerability or ease of use. Effectiveness is a measure of how well the drug works and encompasses all three of these issues. A drug may have very good efficacy but is so unpleasant to take that its actual utility is extremely limited.



<p>© <b>Value added</b></p>	<ul style="list-style-type: none"> <li>➤ Will the treatment/ service/ technology add value in terms of improving the health system's ability to achieve the best health outcomes for available resources?</li> <li>➤ How well does the treatment align with national policy priorities?</li> <li>➤ How will the treatment/ service/ technology enhance or fit into the care pathway? How will it affect the current management of the condition?</li> <li>➤ How compatible is it with the assessed health needs of the population?</li> </ul>
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As can be seen from the above illustrative framework, value systems can be complex and nuanced, demanding delicate balancing and trade-offs between differing ethical beliefs, social ideals and economic considerations. As international evidence demonstrates, they are also deeply local: what is fully acceptable in one culture may be simply unthinkable in another.

## Preparation of Detailed Options for Decision

Once the Joint Committee has consulted widely and Government has agreed a values framework, the Commission will then apply the framework in developing proposals on (1) the precise array of services to be covered in the standard UHI package and funded via UHI, (2) the services to be funded outside of UHI but still provided as part of the overall health basket, i.e. provided by the national public health system and (3) the services to be excluded from the health basket and not funded by the national public health system/ Exchequer.

International evidence indicates the importance of using the framework in conjunction with expert opinion in order to develop a detailed coverage list. While Commission experts will take all views into account, these views will be refracted through the lens of expert judgement, balancing complex clinical and fiscal considerations when reaching conclusions.

In the case of the standard package to be provided under UHI, the final detailed options of the Commission must encompass:

- 1) the type of **service**;
- 2) the **population** qualifying for coverage (e.g. under 18s only versus the whole population);
- 3) any **access or clinical conditions** attaching to provision of the service (e.g. GP referral required, certain clinical indications which must be met etc.);
- 4) any **timeframes** or similar limitations attaching to provision of the service (e.g. cover to be provided for a maximum of 100 days in any 365 day period);

- 5) any **quality and safety requirements** or limitations which must be met in order to qualify for service coverage (e.g. certain treatments are only covered where provided in a centre of excellence or in accordance with certain national standards and guidelines), and
- 6) any **financial protection considerations** (e.g. certain treatments must be fully free at the point of use).

The Commission will also have to explain any cases where its recommendations run contrary to the overall findings of the consultation processes or the values framework.

This detailed coverage list will be submitted to Government as part of costed policy options for final decision and will also be provided to the Joint Committee. The costing process will involve assessing the degree to which demand for services is likely to change under UHI. The determination of which elements are included in the final composition of the health basket will rest with the Government subject to the approval of the Oireachtas.

## Legislating for the Health Basket

While countries can take a more or less explicit approach to defining health baskets, the Irish Government will take the most explicit approach possible when legislating for the standard UHI package of services. This explicit approach will be vital to maintaining social solidarity and social protection under the future model of UHI whereby all individuals will enter into private contracts with their choice of multiple health insurers. In every case, it will be critical that both parties to the contract are bound by the same nationally-defined suite of rights and responsibilities and that these rights and responsibilities are as clear and unambiguous as possible. Only in this way, can the fundamental contract between the State and its citizens in relation to the provision of national health services be upheld.

Finally, an explicit approach will also facilitate a greater degree of control over national health service planning and expenditure, as well as enabling Ireland to better manage its obligations under the EU Directive on Patients' Rights in Cross-Border Healthcare<sup>26</sup>.

## Membership and Working Arrangements of the Commission

The composition of the Commission will be based on the concept of taking a fully person-centred approach to the question of the future health basket. This will involve each member of the Commission standing above and apart from *all* sectoral interests. Each would be expected to act in the interests of the Irish people as both the users and the ultimate funders of the health system, and would be asked to make recommendations based on evidence in relation to population needs.

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<sup>26</sup> As noted in chapter 3, the Directive essentially enables people to seek treatment in another EU Member State in line with entitlements in their home State

Finally, members of the Commission will be required to make a significant commitment over a relatively short time period (e.g. 6-12 months) and will be supported by a dedicated secretariat and relevant technical assistance.

### **4.3 Ongoing Process for Managing the Basket**

Following the initial process of setting the health basket, the Minister for Health, in conjunction with the Minister for Public Expenditure and Reform, will regularly review and update the health basket. It will be necessary to establish clear and permanent structures to support the Minister in this task, as well as to undertake the other key functions associated with ongoing management of the health basket. These functions include:

- assessing new technologies and service developments in order to support the Minister in reviewing and updating the basket,
- updating the underlying values framework, and
- adjudicating on disputes in relation to the interpretation of the basket.

Given the competitive, multi-payer structure of the future insurance-based health system, each of these functions must be assigned to a single, clearly designated authority with a remit which extends across all sectors of the future health system, i.e. all purchasers must be subject to a single, independent and authoritative body.

Having considered a number of different policy options, the Government has decided that the Health Information and Quality Authority (HIQA) is the body best placed to undertake the above functions for the following reasons:

- ✓ HIQA already has statutory responsibility for evaluating the clinical and cost effectiveness of health technologies, including drugs, and for advising the Minister and the HSE of the outcome of such evaluations. In addition, it has a statutory function to review and make recommendations to the Minister in respect of health and personal social services so as to ensure the best outcomes for available resources.
- ✓ HIQA already has an existing function in relation to developing standards for health technology assessment (HTA).
- ✓ HIQA is already representing Ireland in a pilot HTA network at European level, the EUnetHTA, which aims to reduce duplication of HTAs and increase the impact of HTA and its input into policy and decision-making in Member States and at EU level.
- ✓ HIQA already has a solid reputation as an independent authority which stands apart from all purchasers and providers (and which has no role in relation to funding of

services). This is important in terms of public trust in the body which will adjudicate on disputes and in terms of public acceptance of potentially challenging recommendations regarding changes to the basket.

- ✓ HIQA has invested time and resources in establishing robust systems and processes to underpin the effective discharge of its functions and uses adherence to such processes as a measure of its success. As the international literature demonstrates, rigorous and transparent processes are seen as vital in terms of achieving an assessment and decision-making process which stands up to public scrutiny.
- ✓ HIQA's existing role in relation to setting standards for quality and safety of services appears to complement the roles of advising on the composition of the health basket and adjudicating on disputes in relation to the interpretation of the basket. This is because compliance with standards should be a pre-requisite for services being provided as part of the national health basket, i.e. services in the health basket should be defined by reference to quality considerations and purchasers should not have to cover these services where licensing requirements and quality standards are not met. In the UK, NICE now has the dual roles of developing quality standards and issuing binding 'guidance' on new treatments following technology appraisal. Furthermore, in the Netherlands, the body tasked with advising the Ministry on the composition of the basic healthcare package and providing clarification in cases of dispute, also has a role in relation to quality.
- ✓ HIQA has a broad remit which extends across the health and personal social services area<sup>27</sup>. As such, it is arguably well placed to consider the entire health basket, including the issue of service integration and the boundary between services funded as part of the standard UHI package and services funded separately to UHI. By contrast, a body which has specific responsibilities in relation to UHI (such as the regulator of the insurance market) is likely to only focus on those elements of the health basket which are covered by universal health insurance.
- ✓ HIQA is an existing agency which is already resourced and active in the areas of HTA and stakeholder consultation. While the new functions related to the health basket may give rise to a requirement for some additional resources, these are likely to be much lower relative to establishing a new agency.

A more in-depth look at the functions to be delivered by HIQA in relation to ongoing management of the health basket is set out below.

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<sup>27</sup> The one exception is the area of mental health which falls under the remit of the Mental Health Commission.

## Process for Assessing New Treatments and Technologies

As new treatments and technologies emerge, there will be a need to establish whether they should be included in the health basket and, if so, whether they should be part of the standard UHI package. HIQA will support the Minister in reaching such decisions by undertaking assessments in accordance with the following key principles:

- Any party will be entitled to make a submission to HIQA asking it to assess a treatment for the purposes of inclusion in the basket. Depending on the volume of submissions received in any given period, HIQA may have recourse to a filtering or short-listing process so as to ensure the efficient discharge of its functions<sup>28</sup>.
- The new technology or treatment will be assessed against the values framework using such robust, validated assessment tools as HIQA deems appropriate. This should include the use of health technology assessment, where appropriate, but could also include other cost effectiveness tools and approaches.
- The values framework and the assessment tools and procedures used should be publicly available so that the decision-making process is transparent and standardised. In the interests of administrative efficiency, HIQA's procedures should leverage European-wide initiatives in relation to health technology assessment (e.g. the EUnetHTA network) and should take account of validated and relevant research from elsewhere where it is appropriate to do so.
- The conclusions of the assessment, including the rationale for reaching the conclusion, should be published and views invited from interested parties.
- Following receipt of views, HIQA should finalise its recommendations, submit them to the Minister and publish them on its website.
- The Minister will consider HIQA's recommendations and will then have the power to reach a final decision on the new treatment or technology, subject to the approval of the Minister for Public Expenditure and Reform, i.e. recommendations will not be binding on the Minister.

In addition to requirements regarding the publication of both assessment procedures and assessment outcomes, HIQA will be subject to oversight by the Ombudsman's Office in relation to the execution of its health basket functions. This means that any person will be able to complain to the Ombudsman where they consider that HIQA has failed to follow its

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<sup>28</sup> In order to maintain appropriate checks and balances within the system, any proposed filtering or short-listing process will be subject to advance approval by the Minister for Health.

own procedures, has used unfair or unsound administrative practices and procedures, or has based its assessment on erroneous or incomplete information<sup>29</sup>.

## **Process for Assessing Existing Treatments and Technologies**

In order to keep pace with technological development and clinical knowledge, it is important to add new, cost-effective treatments to the basket but it is equally important to remove outdated and inappropriate treatments from the basket. As such, HIQA will also have a vital role in periodically reviewing existing services and recommending their removal from the basket where they no longer meet clinical and cost effectiveness criteria or where a more appropriate or efficient treatment exists. In line with the process for assessing new technologies, HIQA will publish its procedures for undertaking reviews of existing treatments and technologies, as well as its recommendations. As with all national service coverage decisions it will then be a matter for the Minister for Health to take final decisions on whether to remove recommended items from the basket.

## **Process for Updating the Values Framework**

The values framework will need to be regularly updated to reflect the views and values of society. Accordingly, it will be subject to periodic review by HIQA in consultation with citizens and system stakeholders and will be submitted to the Minister for approval

## **Process for Adjudicating on Disputes**

Finally, it may be expected that, from time to time, disputes will arise between purchasers and providers and between purchasers and members of the public in relation to what services are covered under UHI. While these will ultimately be matters of private contract law, the Government plans to establish a practical adjudication process in order to avoid potentially expensive and protracted legal action, and to safeguard the public's interests. The adjudication process will be undertaken by HIQA which will be fully independent in carrying out this function. In other words, the Minister for Health or Government will have no say in reaching decisions on individual disputes.

Under the adjudication process, HIQA will receive complaints made by any person or organisation in relation to the interpretation of the standard package under UHI. On receipt of such a complaint, HIQA will notify all affected parties, asking them to submit any views or relevant information in support of their position. Having considered all views and evidence provided to it, HIQA will then issue a decision which will be binding on the parties concerned, subject to a right of appeal to the courts. In the interests of transparency, it will also publish this decision.

It should be noted that the above process would not negate a person's right to seek redress via the courts and that the courts could overturn a decision of HIQA. However, the intention

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<sup>29</sup> Please note that recourse to the Ombudsman would be precluded where there is already a right of appeal to an independent appeal body, i.e. these are two mutually exclusive policy options available to the Government.

would be to provide a pragmatic and independent process which is helpful to all parties and which avoids the need for expensive and unnecessary recourse to the courts.

## Managing Prior Authorisations

Finally, as highlighted in chapter 3, in order to fulfil the State's requirements under the EU Directive on Patients' Rights in Cross-Border Healthcare, there is a need for a single, national authority which will manage the system of prior authorisations on behalf of all health insurers. Given its independent status and its related role in relation to the interpretation of the health basket, the Government considers that HIQA will be well placed to deliver this task under the future universal health insurance system.

## 4.4 Services covered by UHI

As already outlined, the Government intends to establish a Commission to consult with the public and stakeholders and to prepare detailed recommendations on the future health basket including, in particular, the services to be covered under UHI. In order to guide and focus this work, the Government has also developed overarching policy proposals in relation to the treatment of different service areas within the future health basket. These proposals are summarised below and are set out in detail in the background *Policy Paper on Designing the Future Health Basket*.

### Summary of Policy Proposals on the Future Health Basket

The composition of the future health basket should support the delivery of the overall policy vision set out in chapter 1, namely:

**To develop an efficient and effective single-tier health service  
which promotes equitable access to high quality care on the  
basis of need.**

It should also accord with the overall principles prescribed at the beginning of this chapter (see section 4.1), with individual services defined in accordance with the following criteria:

- To the greatest extent possible, services should be defined by reference to health needs and the nature of the service provided and not by reference to a specific healthcare professional or setting. This will enable continuous innovation and the appropriate use of best practice models and skill mix.
- To ensure uniformity across the domains of healthcare entitlements and healthcare commissioning, services should be defined using the same, standard classification system for the purposes of both the UHI standard package and the UHI payment mechanism.

- Services should be defined by reference to national licensing requirements and quality standards.

Furthermore, the composition of the future health basket should take account of the strategic policy direction set by Government in relation to each of the major service programme areas (see below).

#### ❖ Health and Wellbeing

Keeping people healthy is the paramount goal of the Irish health service. As such, health and wellbeing services form an integral and invaluable part of our health system. However, the population-based focus of health and wellbeing services means that they do not necessarily align well with the decentralised, individualised focus of an insurance-based health system. This is particularly the case when moving towards a multi-payer model. As such, the Government proposes that health and wellbeing services would be excluded from the standard UHI package and financed via a separate Health and Wellbeing Fund.

It must be stressed that, while not covered by UHI, such services will still be a core element of the future health basket, whereby:

- ✓ service provision will be underpinned by legislation (e.g. legislation will stipulate that the Department of Health shall arrange for the provision of particular vaccination services to all members of the population);
- ✓ appropriate organisational linkages will exist at the delivery level (e.g. public health nurses will operate as part of primary care teams and will be aligned with the school system, clear and mandatory referral pathways will exist between screening services and treatment services), and
- ✓ clear funding and accountability mechanisms will exist to ensure local delivery of services (e.g. primary care providers will have a legal obligation to submit health surveillance data to national authorities and to deliver agreed immunisation and/or screening services).

Finally, a notable exception to the above conclusions relates to health promotion and patient education provided as part of structured care and chronic disease management programmes. It is logical that such services would be funded as part of a bundled service package and should, therefore, be included in the standard UHI package where it is decided to include structured care or chronic disease management programmes in the UHI package (see primary care services below).

#### ❖ Primary Care

The Government is committed to strengthening primary care so that it can act as a linchpin of the health system, meeting 90-95% of people's health needs. It, therefore, proposes that every member of the population should be registered with, and have universal access to, a comprehensive, multi-disciplinary primary care team which fulfils the following essential functions:



- providing core healthcare services for the whole population;
- acting as a referral point (gatekeeper) for access to secondary and specialist services and for hospital discharge planning, and
- identifying high risk users and co-ordinating services around their needs.

Primary care services will form a central part of an integrated package of services provided under UHI, with service entitlements provided on a stratified basis, linked to patient need, as follows. At the basic level, every member of the population should have a universal entitlement to core primary care services provided by GPs, practice nurses and public health/community nurses.

At the other extreme, the highest risk healthcare users (i.e. the top 3-5% of the population who account for 40% of all inpatient bed days and who are likely to suffer from multi-morbidities) should be entitled to formal case management support<sup>30</sup>. This would involve assigning a key worker to high risk individuals who would be tasked with ensuring co-ordination and implementation of a structured care plan tailored to the individual's needs. Structured care might involve regular phone calls to remind a patient to take medication, house visits by a health care assistant or nurse to change dressings or more intensive specialised care supports by advanced nurse practitioners or medical consultants. There is powerful international evidence that this type of targeted case management, when implemented properly, can realise significant benefits, both for the individual who experiences better care and better health outcomes, and for the wider health service and its users who obtain better value from health system resources (as measured by reduced acute hospital bed usage and readmission rates amongst high users) and better general access to such services. In other words, high risk users get better preventative care, reducing their need for acute hospital care, freeing up that capacity for others and maximising the value that is achieved for available resources.

At the intermediate level, **members of the population who meet certain clinical or other criteria should be entitled to chronic disease management.**

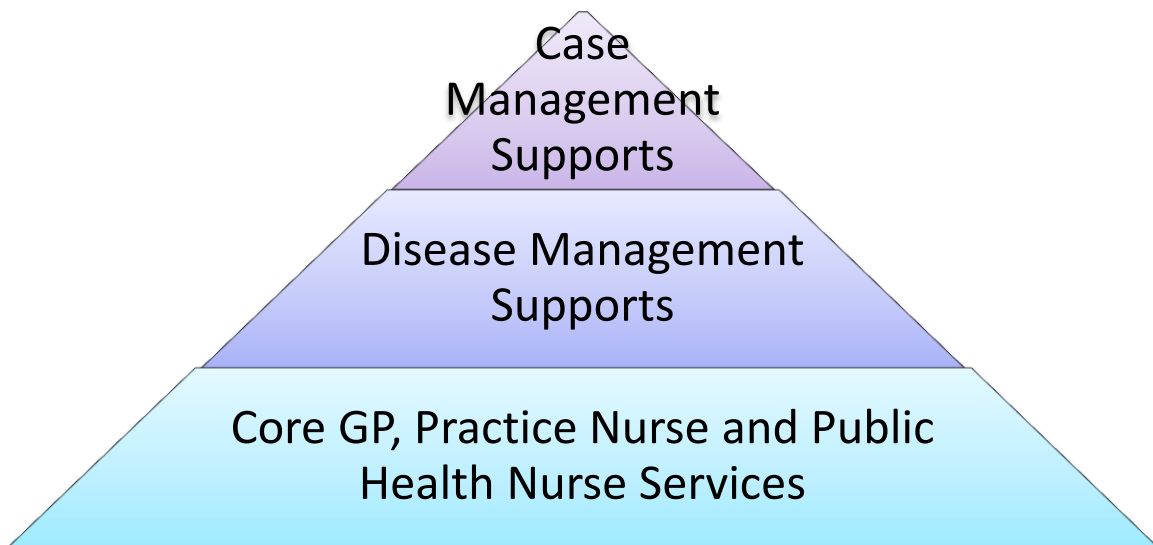
Finally, at a general level, primary care services should work in harmony with public health services to promote population health education and to undertake population screening. In this regard, the Government recognises the key role of the public health nurse, who is positioned at the interface of public health and primary care, and is central to achieving practical integration at the level of the delivery system.

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<sup>30</sup> Other jurisdictions and organisations are able to identify high risk individuals by using predictive analytics to assess populations for clearly defined risk factors. As such, these same risk factors could be used to define entitlement to case management support.

This stratified approach to providing primary care is presented diagrammatically below.

[Figure 4.2: Stratified Provision of Primary Care Services](#)



Internationally, there is a trend towards strengthening preventative and chronic disease management care, while simultaneously rationing services included in the universal health basket. This underscores the need to balance comprehensiveness with sustainability when designing primary care entitlements. The stratified approach outlined above seeks to achieve this balance, both strengthening the focus on prevention and chronic disease, and targeting resources to optimal effect.

#### ❖ [Acute Hospital Services](#)

The Government is committed to achieving a single-tier system of timely access to hospital care based on need and not ability to pay. Consistent with its ‘Money Follows the Patient’ policy, it proposes that the standard UHI package should encapsulate acute inpatient, outpatient and daycase care, including cancer care. Recognising the fundamentally curative nature of rehabilitative care, it further proposes that such care should be included in the standard UHI package subject to an overall time limit (e.g. 1 year). Care provided for a period in excess of a year would be defined as long-term and financed separately (see social and continuing care below).

Finally, given the strong ‘public good’ nature of ambulance and emergency department services, it is suggested that, under a multi-payer UHI model, such emergency services might be most efficiently and effectively provided to the population by being excluded from the standard UHI package and separately State funded. It is noted that this approach could give rise to concerns that UHI premiums would not reflect the true cost of acute hospital care. However, this concern could be addressed relatively efficiently by placing a levy on all UHI policies which would then be used to block grant fund Emergency Department services.

### ❖ Mental Health Services

The Government is committed to the development of a modern, community-based mental health service and to the inclusion of a comprehensive range of mental health services in the standard UHI package. It proposes that everyone should be covered under the standard UHI package for necessary mental health services provided (i) by community mental health teams (including child and adolescent mental health teams), (ii) in out-patient clinics, day hospitals and day centres and (iii) in acute inpatient settings. These services should include addiction counselling, social work and occupational therapy services.

While many people will need these services for only a short period of time, some people may require ongoing care on a long-term or continuous basis. It is, therefore, suggested that a time limit might be stipulated which differentiates between acute mental healthcare included in the UHI standard package and continuous mental healthcare funded outside of the package as part of long-term social care services. In line with this approach, it is proposed that the long-term services provided by community residential units and sheltered workshops would be excluded from the standard UHI package and funded separately. This is also consistent with the Government's commitment in *Future Health* to review the Fair Deal scheme to assess its applicability to the mental health residential sector<sup>31</sup>.

### ❖ Social and Continuing Care Services

Social and continuing care services are provided over an extended period of time to meet physical and/or mental health needs that have arisen for any number of reasons such as frailty, disability, an accident or illness. *Future Health* sets out the Government's vision for the reform of social and continuing care services which embraces the following key elements:

- a person-centred approach which integrates services around the needs of the person and which maximises independence;
- an equitable approach which allocates resources based on standardised care needs assessments and individual care plans; and
- a funding approach based on central commissioning and individualised budgeting which will be separate from the system of UHI.

While the majority of social and continuing care services are provided on a long-term basis, some services are provided on a shorter-term and more flexible basis. The most obvious examples are convalescent care and care provided by community intervention teams. These short-term services are critical when thinking about the boundary between health and social care or the 'care/cure' split. It is, therefore, important to consider both types of service when designing the future health basket.

In line with the Government's policy as set out in *Future Health*, it proposes that social and continuing care services which are long-term in nature would be excluded from the standard UHI package and funded separately via general taxation. This would mean that services

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<sup>31</sup> Please see action 38 in *Future Health: A Strategic Framework for Reform of the Health Service 2012- 2015*.

including meals-on-wheels, home help, home care packages, personal assistance services, day care services, rehabilitative training, sheltered workshops and long-term residential care would be provided on the basis of a care needs assessment and an individualised care plan, and would be funded separately to UHI services. Furthermore, in line with the existing approach adopted in the *Health Act 1970* and the *Nursing Homes Support Scheme Act 2009* as well as the approach proposed in relation to mental health services, it is suggested that such services would be defined by reference to a clear time period, e.g. services which are provided for a period exceeding 30 consecutive days or which are intended to be provided for a period exceeding 30 consecutive days in any twelve month period. This time-bound approach should allow us to retain a significant strength of our current system, namely the fact that health and social care services which are needed on a long-term basis can be funded and provided in an integrated manner rather than being delivered via two distinct systems. This strength is perhaps most clearly demonstrated by the home care package initiative which funds a tailored package of services designed to meet a person's healthcare needs and needs related to the activities of daily living<sup>32</sup>.

Moving from long-term to short-term services, the Government proposes that convalescent and step-down services should be included in the standard UHI package. This will ensure that acute hospital services and step-down services enjoy parity of esteem in terms of an individual's entitlement. In other words, a perverse incentive should not arise by virtue of the fact that everyone would be entitled to acute hospital care whereas convalescent care would be means-tested or rationed in some similar manner. Moreover, by including step-down services in the standard UHI package, it ensures that the same funder is purchasing both acute hospital care and step-down care. This allows payment mechanisms to be aligned so that, on the one hand, funders are not paying for expensive acute hospital care when such care is no longer medically necessary and, on the other hand, acute hospitals are not unfairly bearing the burden of delayed discharges due to cost-shifting between different funders. In summary, the approach should support appropriate patient flow through the health system.

#### ❖ Social Inclusion Services

The focus of social inclusion services is on reaching out to marginalised, vulnerable or excluded groups. Such services can fall into two broad categories: (1) services which substitute for mainstream health services (e.g. primary care outreach services, addiction services) and (2) services which supplement or complement mainstream health services (e.g. domestic, sexual and gender based violence services).

Under UHI, everyone who is ordinarily resident in Ireland will be entitled to obtain healthcare cover from their choice of competing insurer and will be entitled to obtain treatment from their choice of healthcare provider in accordance with the terms of their UHI policy. Consistent with this approach, it is proposed that, where social inclusion services

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<sup>32</sup> Social care services are often understood as services which support a person in relation to the activities of daily living (e.g. washing, dressing and showering) as well as the instrumental activities of daily living (e.g. shopping, cooking etc.).

*substitute* for mainstream health services which are included in the standard UHI package, then these ‘social inclusion’ services should equally be covered by the standard UHI package. This would include where such services are a key element or support for delivery of the main service (e.g. provision of translation services as part of providing acute hospital care). This is in line with the principles of equity and choice which lie at the very heart of the Government’s plans for UHI.

However, where social inclusion services *supplement* mainstream health services, then it would seem reasonable that these more targeted or enhanced supports might be funded separately to UHI, although the Government would welcome stakeholder views in this regard.

#### ❖ Integration of Services

Having systematically considered individual service programme areas, the Government also considered the issue of integration of services across programme areas, particularly in the light of future population health needs.

As a society, the nature of our health needs is changing. The leading causes of ill health are no longer communicable diseases but, rather, chronic conditions often linked to lifestyle factors. This is precipitating a corresponding change in the nature of our health services which are moving away from episodic, reactive care and towards proactive, continuous care management. While this transformation of our health service is vital in order to meet the needs of our population, it inevitably results in some blurring of the lines between acute and continuous care. This can also prove problematic for traditional health insurance systems which are generally focused on short and clearly defined episodes of care. It is for these reasons that the Department asked the Health Research Board to undertake a review of international evidence in relation to the integration of health and social services. That review identified the following features of a successfully integrated health and social care system:

- It encourages integration and integrated care through a regulatory framework.
- It encourages integration and integrated care through a financial framework.
- It provides support to innovative approaches to commissioning integrated services.
- It applies national outcome measures that encourage integrated service provision.
- It invests in continuous quality improvement including publishing outcome data for peer review and public scrutiny.
- It has defined populations that enable health care teams to develop a relationship over time with a ‘registered’ population or local community, and to target individuals who would most benefit from more co-ordinated approaches to the management of their care.
- It aligns financial incentives to encourage collaboration and joint responsibility for the management of ill-health at the lowest appropriate level of complexity.

- It shares accountability for performance through the use of data and public reporting.
- It uses information technology to identify and target ‘at risk’ patients and support the delivery of integrated care.
- It uses guidelines to promote best practice and support care co-ordination.
- It has a physician–management partnership that links the clinical skills of health care professionals with the organisational skills of executives, sometimes bringing together the skills of purchasers and providers ‘under one roof’.
- It ensures effective leadership at all levels and promotes a collaborative culture that emphasises multi-speciality team working by health and social care professionals to deliver highly co-ordinated and patient-centred care.
- It enables patient and carer engagement in taking decisions about their own care and support.

The Government recognises that there is likely to be strong overlap between individuals in need of intensive case management support and individuals in need of social and continuing care services<sup>33</sup>. Therefore, **a logical interface for integration exists between case managers working across primary and hospital care settings and care needs assessment managers working in the social and continuing care area**. The Government intends to develop detailed policy to support integration at this critical interface within the future health system. This policy will set out clear systemic, organisational, clinical, informational, financial and normative processes to deliver integration.

Finally, the Government is also committed to the effective integration of UHI services and child protection services delivered by the Child and Family Agency.

## Policy Options in relation to the Standard UHI Package

It is intended that the policy proposals in relation to each of the major service programme areas will form the basis of consultation and the starting point for developing detailed recommendations, after which Government will make final decisions on the health basket.

In general terms however, it is envisaged that the range of services to be provided under the standard package of UHI will encompass primary and acute hospital services, including acute mental health services.

The inclusion of pharmaceuticals (subject to co-payments) either as part of the standard UHI package or through a separate eligibility scheme replacing both the current General Medical Scheme and Drugs Payment Scheme will be considered. In particular, the Government wishes to continue to cover the drugs costs of the lowest income group, as currently applies to those with medical cards.

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<sup>33</sup> Research from England found that emergency hospital admission was three times higher amongst social care users and that, in any given year, 80% of people over the age of 75 years in receipt of social care will access a hospital service, with 50% being admitted as an inpatient. Source: *Predicting social care costs: a feasibility study* (Nuffield Trust, 2011)

The issue of the services to be provided under the UHI standard package will stand to be considered by the Commission in conjunction with the consultation process facilitated by the Oireachtas Committee on Health and Children. The Commission will make detailed costed options on the services to be provided under the standard package, but the final decision on standard package will rest with the Government.

# 5. Funding Universal Health Insurance

## 5.1 Introduction

Having considered the services which should be provided in the future health system, the next related question is how do we fund those services? In other words, how do we raise the resources required to pay for our health system, especially given that the methods used can have wider efficiency, equity and economic impacts?

To answer this question, the Department has considered the current blend of financing arrangements within the Irish health system, has reviewed funding mechanisms in other jurisdictions and has undertaken an options appraisal of various different approaches. Full details of this work can be found in the background document, *Policy Paper on Raising Resources for Universal Health Insurance*.

On foot of this research, the Government has decided on a preferred funding approach for the future insurance-based health system as set out in section 5.3 below. However, before describing that funding approach, it is useful to begin by briefly explaining the current arrangements which represent our starting point.

## 5.2 Macro-Funding Flows in the Irish Health System

### How Resources are Raised

When speaking about Ireland's health system, we are really referring to two separate but intersecting systems: our national public health system and our voluntary private health insurance system. This 'two-tier' system is funded from a complex blend of public and private financing arrangements which can be broadly summarised as follows.

Within the public health system, the predominant source of funding is general taxation with private financing playing a secondary role in the guise of statutory co-payments and payments for private treatment in public facilities. Private healthcare, provided in both public and private facilities, is funded by private health insurance premiums and direct out-of-pocket payments which, in turn, are supported by direct tax relief for private health insurance premiums and indirect tax relief for medical expenses. An indirect subsidy to the private sector is also provided via the non-charging of some private treatment delivered in public hospitals, although the Government is beginning to reduce this subsidy with the introduction of a new charging regime for private in-patient services from the 1<sup>st</sup> January 2014 in public hospitals.

In addition to the intricate interplay of public and private sources outlined above, the State, via several different schemes, directly reimburses private providers for specified services provided to qualifying individuals. While the majority of these schemes are managed by the



HSE and funded from general taxation, one of these, the Treatment Benefit Scheme, which covers the cost of certain dental, optical and aural services, is operated by the Department of Social Protection and funded via Pay Related Social Insurance (PRSI).

Each of the major funding sources for healthcare is described below, while their respective contributions to health system financing are summarised in figure 5.1.

## General Taxation

General taxation consists of income tax, value added tax levied on goods and services, and various other taxes (including stamp duty, capital acquisitions tax, corporation tax, excise duties, etc.). The majority of healthcare costs are met directly by the Exchequer via general taxation, with direct Exchequer spending amounting to approximately €12.77bn<sup>34</sup> and accounting for approximately 70% of total health spending. However, while still funding the vast majority of healthcare in Ireland, the impact of the economic and financial crisis has seen direct Exchequer spending decrease by 10% between 2009 and 2013, and further expenditure reductions are required in 2014.

## Private Expenditure

Private health expenditure broadly consists of out-of-pocket payments by individuals and expenditure on private health insurance.

***Out-of-pocket expenditure on health:*** This includes spending on GP and other professionals' fees (e.g. consultant specialists, dentists, opticians, etc.), net outlays on prescription medicines, and spending on other medical equipment and services. OECD figures illustrate that out-of-pocket payments in Ireland have been rising as a proportion of overall health spending and amounted to almost €2.6bn or 18% of total health expenditure in 2011. The Consumer Price Index for health would suggest that this rise in spending is related to corresponding price increases in the underlying costs of certain health services.

Tax relief at the standard rate is available for most unreimbursed out-of-pocket medical and dental expenses, including treatment provided in another jurisdiction<sup>35</sup>. In 2011, tax relief of €131m was paid to 384,300 claimants.

***Private Health Insurance:*** Almost 45% of the population hold private health insurance, paying over €2bn in annual premiums. Actual expenditure on healthcare by private health insurers accounts for just under €1.8bn<sup>36</sup> or 12% of overall health expenditure. This reflects an increase in recent years in the proportion of overall health expenditure relating to private health insurance and is mirrored by upward trends in premiums.

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<sup>34</sup> This figure refers to gross current expenditure on health (Vote 38 and 39) for 2014.

<sup>35</sup> The one exception is fees for nursing home care where relief can be claimed at the higher rate.

<sup>36</sup> This 2011 figure is calculated based on 2011 claims expenditure by open market and restricted membership schemes, and 2011 cash grant payments by the Hospital Saturday Fund.

As with out-of-pocket expenses, private health insurance premiums attract standard tax relief. This relief is granted at source to all subscribers. The total value of this tax relief had been increasing in line with premiums increases and equated to €404m in 2011. In order to encourage better cost control within the PHI market, Budget 2014 capped the amount of premium on which tax relief will be available to €1,000 per adult and €500 per child. Only the portion of any premium which exceeds the new thresholds will not qualify for tax relief<sup>37</sup>.

**Statutory charges:** Finally, statutory charges amounting to €655m were raised in 2011 and were met from either out of pocket payments or private health insurance payments.

### **Treatment Benefit Scheme**

Earmarked revenue for healthcare is also provided on a limited basis via Pay Related Social Insurance (PRSI). PRSI contributions are based on a percentage of the employees' reckonable earnings and are payable by both the employer and the employee. Different classes of PRSI contribution exist but most employees are covered by Class A1 which involves an employee contribution of 4% and an employer contribution of 10.75%.

Contributions are collected by the Revenue Commissioners and paid into the Social Insurance Fund. They are then used to fund social welfare benefits and pensions, including some health related benefits. These health related benefits are provided via the Treatment Benefit Scheme, which is operated by the Department of Social Protection and which provides dental, optical and aural services to people who meet the qualifying conditions. Various changes have been made to the scheme since 2010, the net effect of which has been to reduce expenditure which stood at €23m in 2011 and €19m in 2012.

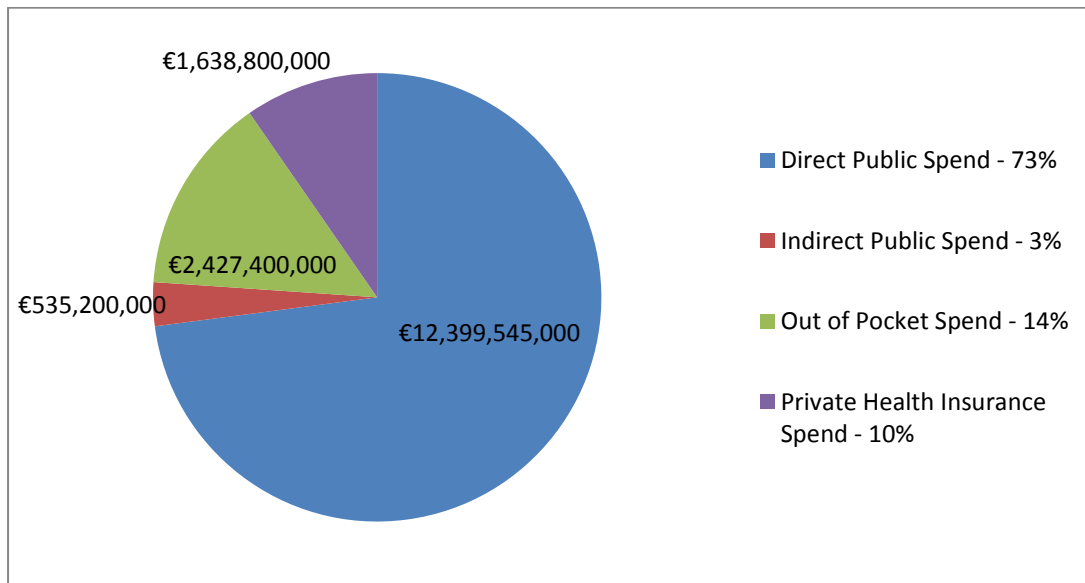
### **Summary Conclusion**

In summary, the majority of healthcare costs are met by the Exchequer, either directly (73%) or indirectly via medical expenses and medical insurance tax relief (3%). The balance of healthcare costs are met through private expenditure, with *net* out-of-pocket costs and *net* private health insurance costs equalling 14% and 10% respectively. This is reflected below.

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<sup>37</sup> It should be noted that a separate system of age-related tax credits is used to support risk equalisation and that these credits are deducted from the gross premium before the standard tax relief at source is applied.

[Figure 5.1: Breakdown of Overall Health Expenditure 2011](#)



## How Resources are Pooled and Managed

The pooling of resources generally refers to the accumulation of prepaid funds on behalf of a population. The concept is fundamental to any insurance system where contributors insure themselves against the often catastrophic cost of an accident or illness. However, it can also be central to a national health system's ability to achieve equity and efficiency objectives: in most countries publicly collected funds for healthcare are pooled nationally, thereby ensuring (i) that the healthier and wealthier subsidise the poorer and sicker, and (ii) that resources are used efficiently and in accordance with nationally determined needs.

As noted earlier, Ireland has a two-tier health system funded from a mix of public and private sources. Perhaps, not surprisingly, it also has two major mechanisms for pooling and managing health resources at a national level. In the case of the public health system, general taxation revenues are collected by the Revenue Commissioners, pooled centrally by Government and an estimates process is embarked upon to determine the level of expenditure for each Government Department/Agency. In the case of the private health system, community-rated private health insurance premiums are subject to notional pooling via a risk equalisation scheme which balances the resource risk associated with insuring older, sicker customers across the market. It does this by collecting a stamp duty payable on each insured life into a central pool and then using this to fund a system of risk equalisation credits (see figure 5.2 below).

In both cases, the pooling of resources achieves a fundamental social solidarity objective, ensuring that the healthier cover the costs of those in need of care. Both systems are also concerned with efficiency: at the heart of the public estimates process lies core decisions on allocative efficiency when choosing between various social and economic programmes, while the risk equalisation scheme is concerned with correcting market failure associated with risk selection, thereby shifting insurer focus back to delivering value for customers as a whole.

However, at an overall level, the existence of a separate, voluntary private pool can undermine social solidarity and hamper national visibility and management of healthcare resources. Furthermore, some healthcare resources are not taken account of within either of the national pooling mechanisms or are subject to separate pooling arrangements, e.g. medical expenses tax relief and contributions to the Treatment Benefit Scheme.

[Figure 5.2: Risk Equalisation Process](#)



## How Resources are Allocated

Having pooled public health resources into the overall health budget (the Health Group of Votes), the public health system then uses a national service planning process to set prospective budgets for different service areas and providers. The HSE is, essentially, the central hub for the distribution of public funding for health services. Each year, it prepares a National Service Plan setting out the type and volume of health and personal social services to be delivered for the monies allocated to the HSE Vote. The Plan is intended to reflect Government’s priorities for the health service as set out in the Programme for Government, *Future Health* and the Department of Health’s *Statement of Strategy*, and must be formally approved by the Minister for Health and published.

Whereas public funds are essentially allocated via a single, national plan, the private insurance market is characterised by multiple insurers concluding contracts with multiple providers. Furthermore, while the public health system uses capped, prospective budgets, the private insurance system generally operates on a retrospective basis. Although prices are agreed in advance, funding is allocated on receipt of individual patient claims and overall

expenditure is thus determined on a largely ‘demand-led’ basis. The Treatment Benefit Scheme similarly uses provider contracts to pre-agree prices but then makes payments based on demand<sup>38</sup>.

Finally, the systems of tax relief for both medical expenses and private health insurance are retrospective, with overall expenditure determined by both the volume and cost of claims received. The one exception is the recent policy change whereby tax relief on health insurance premiums is capped based on a maximum premium of €1,000 per adult.

## Concluding Overview of Funding Flows

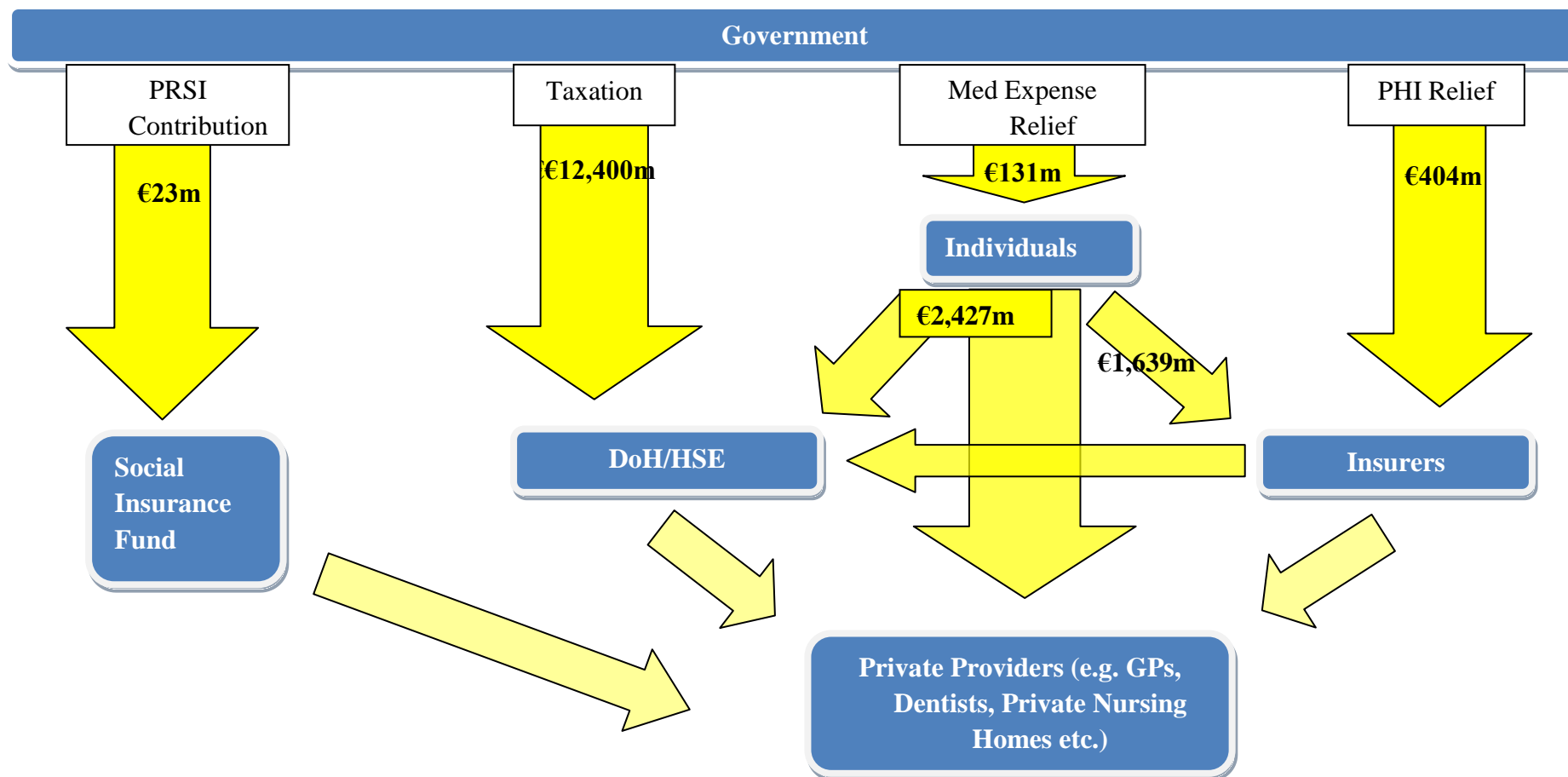
This section has painted a high-level picture of current health sector funding flows in Ireland, including how resources are raised, how they are pooled and managed, and how they are allocated across the public and private sectors. Figure 5.3 below provides a simplified illustration of these macro-funding flows using 2011 data. It demonstrates how the Government supports healthcare through four different channels, namely (1) through the direct provision of funding to the Department of Health and HSE (€12,400m), (2) through the payment of tax relief at source on private health insurance premiums (€404m), (3) through the social insurance system (treatment benefit scheme - €23m) and (4) by reimbursing individuals directly in respect of out of pocket medical expenses (€131m).

The HSE is both a provider and a purchaser of services. As a *provider* of health services, it obtains the vast majority of its funding directly from the Exchequer but also receives monies in respect of statutory charges from individuals and private health insurers. As a *purchaser* of services, it makes payments to private providers (e. g. GPs, nursing homes), as do several other purchasers: individuals, insurers and the Department of Social Protection. Finally, the figure illustrates how individuals, while paying €1.6bn in net health insurance premiums, actually pay considerably more in direct, out of pocket payments for public and private health services (€2,427m).

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<sup>38</sup> While, in practice, no caps are placed on provider contracts or on the number of qualifying individuals who can avail of services, section 138(3) of the *Social Welfare Consolidation Act 2005* provides that payments under the scheme shall not exceed in aggregate sums agreed between the Minister for Social Protection and the Minister for Finance.

Figure 5.3: Macro Funding Flows across the Irish Health System- based on 2011 data<sup>39</sup>



<sup>39</sup> It should be noted that the direct taxation figure of €12,400m includes HSE funding relating to child protection services. A new Child and Family Agency has been established which has responsibility for the future delivery of such services.

## 5.3 Future Funding Arrangements under UHI

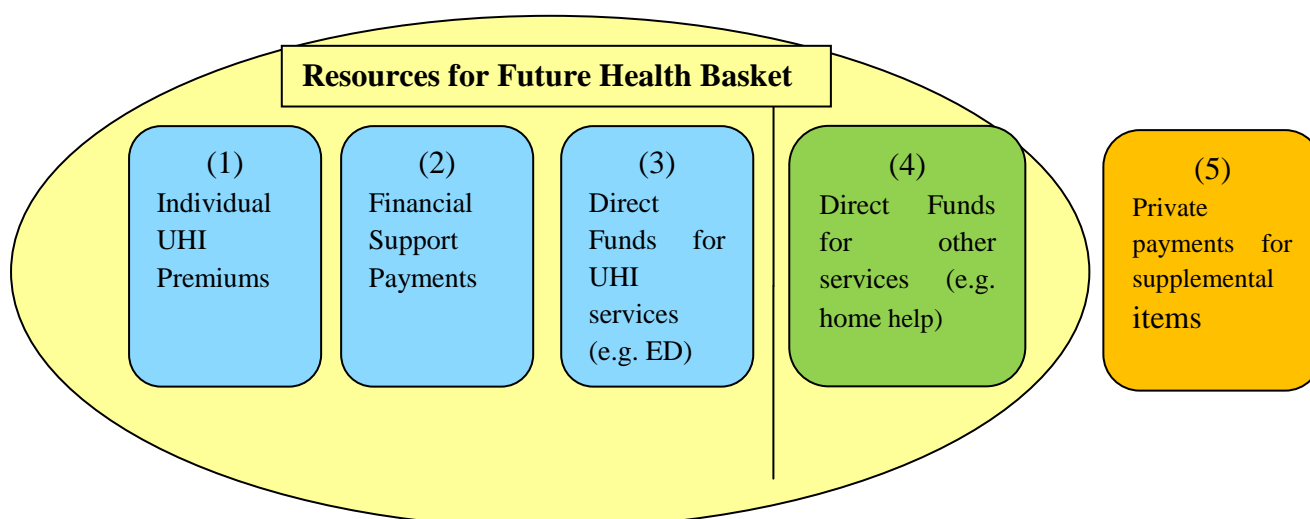
The move to UHI involves a seismic shift in how we finance and organise our health system. In the case of all services covered by the UHI system, it requires that we rationalise the current multiple funding and pooling arrangements into a coherent structure. The Government's preferred model of UHI, as described in Chapter 3, provides the overarching template in terms of prescribing how these new financing arrangements will work.

Firstly, health insurers will, individually, set the levels of the health insurance premiums which each will charge for the standard package of services provided under UHI. As with the current private health insurance market, people will pay their health insurance premium directly to their chosen insurer (1). The State will subsidise these private payments in two ways: by providing financial support towards the cost of UHI premiums (2) and by directly funding certain UHI services or costs (3).

Where services form part of the national health basket but are not part of the standard UHI package, the State will also continue to directly fund these services (4).

Finally, under the preferred model of UHI, individuals can still purchase voluntary supplementary private health insurance or can pay privately for items outside the standard UHI package (5). As such, this will represent a fifth funding source within the future health system. These overarching funding arrangements are illustrated in figure 5.4 below.

[Figure 5.4: Overall Template for Future Financing Arrangements](#)



Given the above parameters as set out by the preferred UHI model, the resulting policy questions in terms of future financing are:

- What is the optimal way to raise resources to fund State subsidies under UHI (i.e. to fund the financial support payments and the direct service costs met by the State)?
- How should State resources be pooled and managed?

The Government's plans in relation to each of the above questions are set out below.

## Raising State Resources for UHI

In order to decide on the optimal method for raising resources, an options appraisal of different funding mechanisms was undertaken. The appraisal looked at a range of options, including:

- ❖ **Payroll tax:** A traditional PRSI type contribution levied on earned income.
- ❖ **General taxation:** This consists of resources raised from across the broad spectrum of direct and indirect taxation.
- ❖ **Ear-marked tax:** A form of specific tax linked to healthcare but not necessarily limited to earned income, e.g. 2% of all income or a dedicated tax on unhealthy consumption.

The appraisal then systematically assessed each of the above options against a range of policy criteria derived from core principles identified by the European Observatory on Health Systems and Policies in conjunction with the World Health Organisation (see box 5.1 below).

### Box 5.1: Principles in relation to Revenue Raising for Healthcare

**Ensuring adequate levels of statutory resources in order to safeguard equitable access to health services:** In broad terms, countries with a greater dependence on mandatory contributions achieve greater equity of access to services and better financial protection.

**Ensuring stability and predictability in revenue flows in order to sustain the delivery of services:** Significant year on year fluctuations in the level of funding available can be highly disruptive to the sustained delivery of services and undermine strategic planning and commissioning.

**Fairness with respect to the burden of financing health services:** OECD research has found that direct taxes and social insurance contributions are progressive while out of pocket payments are always regressive.

**Efficiency and transparency:** The collection of revenues incurs administrative costs and, so, consideration must be given to the most efficient mechanisms for raising revenue. In addition, public acceptability of revenue raising mechanisms can be greater where there is transparency and satisfaction with respect to how that revenue is spent.

**Non-health concerns such as impact on wage competitiveness:** Demographic and economic considerations must also be taken into account when evaluating approaches to revenue raising.



On foot of this work, it was found that general taxation appears to offer several notable advantages as follows.

**Fairness:** General taxation is generally fairer than either social insurance payroll contributions or ear-marked taxes. This is due to the fact that it is typically more progressive and treats different classes of income equally. By contrast, ear-marked ‘sin’ taxes are considered regressive, proportionately affecting those on lower incomes to a greater degree, albeit that they can serve an important public health function in certain circumstances.

**Competitiveness:** The evidence tends to suggest that general taxation may also perform better than payroll contributions in relation to economic competitiveness. This is due to the fact that it offers Government the flexibility to spread the tax burden across a broad funding base. By contrast, payroll-related contributions are essentially limited to earned income, thereby placing the full financing burden on labour.

A number of separate studies stress the importance of competitive labour costs for employment creation. For example, OECD (2008) highlights the advantages of non-direct taxes over direct payroll taxes as regards growth in GDP<sup>40</sup>. Indeed, the importance of protecting competitiveness in the face of rising healthcare costs is apparent in recent policy decisions across a number of countries where employer contributions have been frozen, or even reduced, while the funding share from general taxation has increased.

On a related note, the ability to spread the financing burden beyond payroll contributions is also vital in a time of ageing societies characterised by shrinking labour markets and growing dependency ratios.

Finally, while ear-marked consumption taxes probably display the least negative impact on economic competitiveness, they simply do not raise sufficient resources to meet overall health system costs, i.e. it is accepted that they fail the ‘adequacy’ test. Ear-marked taxes also remove Government discretion and flexibility in terms of how to raise healthcare resources.

**Efficiency and System Disruption:** General taxation is relatively efficient as a means of raising revenue. The Revenue Commissioners already have well established mechanisms in place to facilitate the efficient collection of general taxation and so no additional administrative burden or system disruption arises where this is used to fund statutory resources for UHI. By contrast, a payroll contribution would require the calculation and application of new contribution rates, while ear-marked taxes can give rise to a considerable additional administrative burden and significant system disruption. A notable example in this regard is the application of a fat tax in Denmark which was reported by the Danish Chamber

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<sup>40</sup> Johansson, Å., Heady, C., Arnold, J., Brys, B., and Vartia, L., et al. (2008), “Taxation and Economic Growth”, *OECD Economics Department Working Papers*, No. 620, OECD Publishing.

of Commerce to have increased industry costs by nearly €27 million and which was repealed in 2012<sup>41</sup>.

**Stability and Adequacy:** Finally, some traditional arguments in favour of payroll contributions and ear-marked taxes are the stability of the revenue base and the transparent link between revenues and entitlements, both of which can be regarded as contributing to adequate levels of statutory resources. However, two points are notable in this regard. Firstly, ear-marking of resources doesn't necessarily guarantee stability or adequacy. For example, in times of high unemployment, revenue from payroll contributions may be expected to fall away, even while healthcare expenditure continues to climb. Indeed, it could be argued that general taxation provides a broader base from which to draw and is, therefore, better equipped to ensure the adequacy of statutory resources, particularly in challenging economic times. Secondly, what *is* likely to support the adequacy of resources is the stipulation of explicit service entitlements which must be funded. This is an essential feature of the Government's preferred UHI model (people will have an absolute entitlement to a financial support payment once they meet qualifying criteria) and, therefore, this will apply regardless of how resources are raised.

The analysis as summarised above suggests that there is no compelling reason to move away from our current funding mechanism of general taxation and, indeed, international trends highlight a strong shift *towards* general taxation. Accordingly, the Government plans to retain general taxation as the core mechanism for raising resources. However, it will introduce some important changes in how these funds are allocated, pooled and managed as set out below.

## **Pooling and Managing Resources for UHI**

As noted at the outset, under a multi-payer insurance model, overall UHI expenditure is essentially determined by health insurers when actuarially forecasting claims costs and using this to set premiums for the year ahead. State funding will be largely contingent upon the level of these premiums and their relationship to levels of income across the population. This is because UHI will be mandatory and State financial support will be aimed at bridging the gap between what people can afford to pay and the full cost of an efficient UHI premium. Accordingly, Government allocations to the UHI system will take account of the efficient market rate (i.e. a reasonable UHI premium as set by an efficient insurer), the numbers qualifying for financial support and average amounts of financial support payable having regard to income levels/ means-test criteria etc. Effective cost control will be achieved via the cost control regulatory framework outlined in chapter 3.

In addition, Government allocations will be managed in coherent, whole of system way as follows:

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<sup>41</sup>Petantchin, V. (2013) "*Nutrition*" taxes: the costs of Denmark's fat tax, IEM Economic Note, Institut Économique Molinari.

Firstly, the Oireachtas will determine the overall allocation for health which will comprise several elements, including: (1) financial support payments for UHI, (2) the budget for direct funded UHI services and (3) the budget for all other health basket services (e.g. health and wellbeing services, social care services). This overall allocation will be pooled initially into the Department of Health Vote.

In the case of items (1) and (2) above, the Department will transfer the approved funding to the National Insurance Fund. As noted earlier, the Fund will have responsibility for directly financing certain UHI services (e.g. Emergency Department services or high cost cases). It will also have responsibility for undertaking financial assessments and managing financial support payments to insurers in respect of UHI premiums. Aligned with this latter task, the new Fund will take on two additional financing functions.

- ❖ *Management of Payments related to Standard Tax Relief:* The existing system of standard tax relief on health insurance is already a subsidy to the private health insurance market. Running two separate systems of financial subsidy undermines transparency and is administratively wasteful. On the assumption that tax relief on premiums continues (an issue which the Government may wish to examine further nearer will consider as a part of tax-policy in each of the Budgets up to the time of introducing UHI) it is also proposed to subsume it into the overall system for financial support for UHI on a revenue neutral basis. A base payment would be paid on behalf of everyone through the Insurance Fund with additional financial support payments linked to a means test and ability to pay.
- ❖ *Management of Risk Equalisation Payments:* Consistent with the move to a single, integrated system, it is suggested that risk equalisation stamp duties would also be pooled into the National Insurance Fund which would then be responsible for managing the payment of risk equalisation credits to insurers. This will allow the Fund to manage financial transfers in respect of both income status (i.e. financial support payments) and risk status (i.e. risk equalisation payments) in the most efficient manner, including the use of singular transactions where appropriate. It facilitates greater transparency by ensuring that all financial and related information flows are managed from a single, national hub and further enables the linking of anonymised datasets for the purpose of gaining a deeper understanding of drivers of population health need. In short, the approach should contribute to better management of our health system.

Finally, the system of medical expenses tax relief will be kept under review as UHI is rolled out.

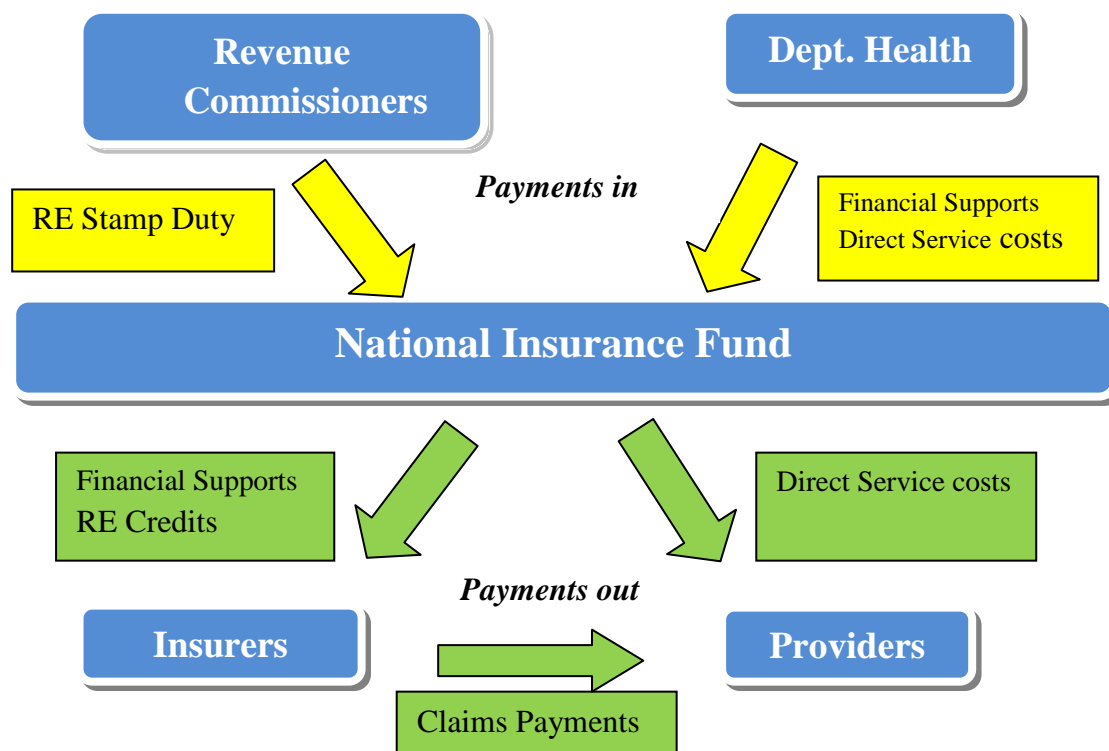
## Summary Conclusions

The above approach to managing resources means that all State funding for UHI (i.e. general taxation funding for financial support payments, including the current standard tax relief payment, general taxation funding for meeting direct UHI service costs, and stamp duty funding to support risk equalisation credits):

- ✓ is collected by the same, single authority, the Revenue Commissioners,
- ✓ is ultimately pooled into the same, single entity, the National Insurance Fund, and
- ✓ is allocated by the same, single entity, the National Insurance Fund.

This streamlined process is represented in figure 5.5 below.

Figure 5.5: Management of UHI Funding Flows



## 5.4 What will UHI Cost?

When considering funding arrangements, a key question for Government and for society as a whole is what will UHI cost the Irish people. The answer to this question is contingent upon a range of critical and interconnected variables, including:

- ❖ **The Need for Healthcare:** The population's need for healthcare is determined by various epidemiological factors, including the rate at which our population is ageing and, more importantly, the prevalence of chronic disease and disability within our population.

- ❖ **The Use of Healthcare:** The population's use of healthcare services is affected, not only by their need for care, but also by other potential factors such as the availability of supply, consumer expectations and supplier-induced demand.
- ❖ **Service Delivery Models:** The cost of healthcare reflects the underlying model of service delivery. For example, our current reactive and hospital-centric model of care is not best placed to deal with the rising incidence of chronic disease and multi-morbidity. As highlighted in chapter 4, a shift to community-based case management, particularly for those with the greatest care needs, could result in better quality care at lower cost.
- ❖ **Payment systems:** How we pay providers is key to the cost of the future UHI system. This speaks to the central importance of carefully designing payment systems which mitigate supplier-induced demand and which encourage the delivery of integrated care at the lowest level of complexity that is safe, timely, efficient and as close to home as possible.
- ❖ **Payment rates:** In addition to the design of service delivery models and payment mechanisms, the price of services is also affected by the underlying cost base which, in turn, reflects the cost of living, national wage agreements, the relative market power of different healthcare professional groups, economies of scale etc.
- ❖ **Regulatory and administrative costs:** Finally, the cost of UHI is affected by the particular regulatory and administrative structures established as part of any healthcare model or system, thereby underscoring the importance of efficient and effective system design.

The ultimate cost of UHI will be a reflection of the State's success in managing all of the above variables as we progress along the path to UHI. As such, it will represent a constant moving target, dependent on the introduction of:-

- initiatives to improve population health,
- effective community-based models of care,
- an efficient Money Follows the Patient funding model,
- standardised, value for money contracting arrangements for GPs and consultants etc.

Therefore, when calculating the cost of the future UHI system, the State is essentially involved in a continuous and highly specialised exercise which must model all of the above variables and the interactions between them, taking account of changes over time and forecasting future trends.

Finally, in order to support accurate actuarial costing and robust ongoing financial management of the future UHI system, the Government plans to progress the following early steps:

- ✓ Establish mandatory financial reporting requirements across the public and private sectors so as to support robust and accurate mapping of health system funding flows, e.g. expand the use of the HIPE system to encompass full coverage of all public and private hospital treatment, enhance the HIA's existing information collection role, etc.
- ✓ Rationalise allocation and payment mechanisms across the public and private sectors as envisaged in the Government's *Money Follows the Patient Policy Paper*.

These steps will support the sophisticated ongoing financial modelling needed to plan and manage the transition to UHI.

## 6. The Path Ahead

### 6.1 Introduction

The purpose of this White Paper has been to present the Government's plans in relation to universal health insurance. As such, it has sought to outline the major contours of the future UHI landscape as reflected across three fundamental policy domains, namely:

- Ⓢ The Model of UHI for Ireland
- Ⓢ The Standard Package of Services
- Ⓢ Funding of UHI

It has also mapped out the building blocks which will prepare the way for UHI, providing the bridge from our current health system to the future insurance-based landscape. This final chapter looks at how we move across that bridge by briefly describing the key stages of the reform journey which lies ahead.

### 6.2 Major Stages of Reform

The journey to UHI will involve three major and overlapping stages. The first is the structural reform of the health service; along with reform of the PHI market. This is essential, in advance of the move to UHI, to support the transformation to a more efficient, model of service delivery. The second phase is the introduction of health reform legislation giving effect to the purchaser/provider split which is central to any multi-payer insurance model. The third, and final, stage is the phased introduction of UHI from 2016 onwards.

#### Universal Primary Care

The Programme for Government committed to universal primary care, removing fees for GP care, within the Government's term of office. The Programme stated that a phased approach would be taken to implementation, including extending access to subsidised care as a stage in the process. The goal under UHI is to create an integrated system of primary and hospital care, to honour Government's commitment to reforming our model of delivering healthcare so that more care is delivered in the community, at the lowest level of complexity and cost, and as close to home as possible.<sup>42</sup>

As the first step on this journey, Budget 2014 pledged €37 million for the introduction of free GP care to every child under six years of age in Ireland. This initiative will bring immediate benefits for young children and their parents, many of whom have been deeply affected by the economic and financial crisis. However, it will also bring important lifetime benefits,

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<sup>42</sup> Government for National Recovery 2011-2016, p.32

both for our children and for our society as a whole in terms of ensuring early intervention, encouraging healthy behaviours from a young age and reducing long-term healthcare costs.

Proposals to advance the delivery of universal primary care will be progressed throughout 2014 and 2015. The Department of Health is currently developing a costed preferred option paper which will inform Government considerations in this regard; this paper will be finalised over coming months. It will be supported by a new GP contract which will encourage better care management in the community and require GPs to work as part of multi-disciplinary primary care teams.

## **Structural Reform & Legislation**

Good progress has been made on the first phase of structural reform, which included the introduction of new HSE governance and management structures, establishment of hospital groups on an administrative basis, establishment of the Child and Family Agency, and the publication of the Bill to transfer the Vote back to the Department of Health.

Phase 2 of the reform process involves the establishment of a purchaser/provider split in the health system. In order to deliver on this, work is underway on health reform legislation which will abolish the HSE and replace it with a range of new purchaser and provider and regulatory entities, including the Healthcare Commissioning Agency, independent Hospital Trusts, new primary and community care organisations, a Healthcare Pricing Office and a Patient Safety Agency. The legislation represents a critical interim step on the path to UHI as it will legally create a purchaser/ provider split, thereby preparing healthcare providers to operate as independent entities in the future market-based health system. Under the new system, the Department of Health will have a central governance and policy development role in relation to the health service.

## **Phased Introduction of UHI from 2016 to 2019**

The final phase of reform will see private health insurers subsume many of the purchasing functions of the Healthcare Commissioning Agency as UHI is introduced for all members of the population. In addition to all of the organisational groundwork outlined above, a comprehensive legislative framework for UHI will be put in place during this Government's term of office. This framework will be set out in a Universal Health Insurance Act and will embrace all the major dimensions of the future UHI system. As such, it will:

- establish the core principles and legal requirements governing operation of the UHI market;
- define the future health basket, including the standard UHI package for which every member of the population must obtain insurance;
- establish a system of financial support towards the cost of UHI premiums and set out the criteria governing entitlement to financial support;



- provide for a cost control regulatory framework, including prescribing the payment and contractual arrangements to which all insurers, providers and healthcare professionals must adhere, and
- provide for various low cost dispute resolution mechanisms in cases where contract negotiations break down or there is disagreement over the interpretation of either the standard UHI package or of contractual terms and conditions.

## 6.3 Next Steps

The aim of the reform programme is to deliver a health system which provides Irish people with the best health outcomes for available resources. The Government is keen to engage with society on its plans for achieving this: after all, it is the public's money that is being spent and their health that is affected. Therefore, the next steps on UHI will involve a general written consultation process on the White Paper. Aligned with this, the Government will establish a Commission to lead in-depth engagement with all stakeholders on the particular issue of setting the future health basket.

Finally, it must be stressed that consultation will not delay progress on UHI. Rather, preparations will continue apace across the broad spectrum of the health reform programme. The building blocks for UHI will be carefully set in place, each focused on incrementally improving our health service so that it provides equitable, sustainable and responsive care to each and every member of Irish society.