

## **Health system responses to financial pressures in Ireland: policy options in an international context**

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## **Note on the report**

The Irish Department of Health commissioned the European Observatory on Health Systems and Policies to prepare this report as part of a ‘rapid response’ mechanism to provide a quick review of the evidence on a specific policy question. It was agreed that the report would be authored jointly with the WHO Regional Office for Europe. The Irish Department of Health is not responsible for the report’s content or for any use of the information it contains. Responsibility for the views expressed in the report, and any errors, rests with the authors.

The authors are grateful to the Department of Health for providing information and for their helpful comments on an earlier version of the report, and to Claire Coleman for administrative support.

## List of abbreviations

ACSC	Ambulatory Care Sensitive Condition
CAG	Comptroller and Auditor General
CDS	Community Drugs Scheme
CPI	Consumer Price Index
COPD	Chronic Obstructive Pulmonary Disease
CNAMTS	Caisse Nationale d'Assurance Maladie des Travailleurs Salariés
CSO	Central Statistics Office
DP	Drugs Payment
DPS	Drugs Payment Scheme
DRG	Diagnosis-Related Group
EEA	European Economic Area
EU	European Union
EU-15	Fifteen EU Member States prior to enlargement in 2004 and 2007
EU-27	Twenty-seven EU Member States following enlargement in 2004 and 2007
FEMPI	Financial Emergency Measures in the Public Interest Act 2009
GMS	General Medical Services
GNP	Gross National Product
GP	General Practitioner
HSE	Health Service Executive
HTD	High-Tech Drugs
IHCA	Irish Hospital Consultants Association
IMB	Irish Medicines Board
IMF	International Monetary Fund
IMO	Irish Medical Organisation
INN	International Non-Proprietary Name
LTI	Long-Term Illness
MIC	Maternity and Infant Care
NCHD	Non-Consultant Hospital Doctor
NESF	National Economic and Social Forum
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
P4P	Pay For Performance
PCRS	Primary Care Reimbursement Service
PCT	Primary Care Team
PHI	Private Health Insurance
PRSI	Pay Related Social Insurance
TILDA	The Irish Longitudinal Study on Ageing
UHI	Universal Health Insurance
UK	United Kingdom
USC	Universal Social Charge
USD	United States Dollar
WHO	World Health Organization

## Summary of key points

- The Irish health system is experiencing unprecedented reductions in public spending. Cuts to the health budget are compounded by underlying cost pressures, some caused by weaknesses in the health system (high salaries, high drug prices, poorly developed primary care, means-tested benefits), some caused by factors beyond the health system's control (substantial population growth, economic recession).
- So far, cuts in public spending on health have been mainly achieved through reduced pay for staff, improved efficiency in service delivery and, to a lesser extent, increases in the financial burden falling on users.
- Although there is scope to make substantial additional savings through efficiency gains, these cannot be made within the required timeframe without damaging patient care, unless high salaries and the high price of other inputs are seriously addressed.
- If this is not feasible, the Government should consider establishing a mechanism to compensate the Department of Health and the Health Service Executive for unavoidable increased demand for health and long-term care.
- Efficiency gains from planned and additional reforms will not be sufficient to fund the Government's commitment to establish universal access to primary care and strengthen service delivery.
- Given Ireland's health challenges and its outlier status in terms of health coverage, these commitments are important steps. To achieve them, the health system will require additional revenue.
- Reduced public spending on health services in 2012 and 2013 comes after several years of cuts and organisational changes. Achieving planned reforms will require stronger management of service delivery and organisational stability to ensure clear lines of responsibility and accountability.

## **1 Introduction**

The Irish Department of Health commissioned the European Observatory on Health Systems and Policies (the Observatory) to prepare this report as part of a rapid response mechanism to provide a quick review of the evidence on a specific policy question. It was compiled by a team of international and Irish researchers led by the Observatory and the World Health Organization (WHO) Regional Office for Europe. The Observatory is an international partnership hosted by WHO. The partnership includes three other international agencies (the European Commission, the European Investment Bank and the World Bank), several national and decentralised governments, including Ireland, and academic institutions. As an independent and neutral knowledge broker the Observatory's core mission is to inform policy- and decision-making processes by providing tailored, timely and reliable evidence on health policy and health systems.

Having requested this report, the Irish Department of Health was closely involved in the exercise by highlighting key areas of concern, providing data and reviewing material. The authors worked within a tight timeframe so that the report could inform health budget discussions for 2013, which are expected to be challenging in light of the budget cuts that have taken place since the start of the financial crisis.

The main aim of this report is to review in a concise but rigorous way the main policy options available to the Irish Government in responding to the effects of the financial crisis on the Irish health system. It attempts to assess the response of the Irish health system to budget cuts in recent years and to explore future options in light of relevant international evidence drawn from experiences in European and OECD countries facing similar challenges. In contrast to the narrow time frame that fiscal pressures sometimes impose on policy makers, the analysis here takes a longer term approach to addressing the challenges generated by austerity.

The report begins by analysing the major pressures the Irish health system is facing in terms of fiscal constraints, health expenditure trends, demographic trends and current health system arrangements. It then reviews various policy levers for addressing these challenges, focusing on changes to the level and mix of statutory resources for health; changes to health coverage; and the scope for improving health services efficiency. The concluding chapter summarises the main lessons highlighted by the analysis and discusses implementation issues.

Due to time and space constraints, the report is not intended to be a systematic or exhaustive review of measures that might improve health system performance. Rather, it focuses on options relevant to the Irish situation in the context of severe fiscal pressures. These options were discussed in a policy dialogue ‘Health system responses to the financial crisis in Ireland: assessing impacts, exploring options’ that took place at the Department of Health in Dublin on 16 and 17 July 2012. Leading and senior-level representatives from the Irish Department of Health attended this meeting together with the main people involved in preparing the report.

Chapters three to five adopt a common approach. First, they describe guiding principles and policy objectives. Second, they look briefly at the Irish situation, reviewing key policy proposals or changes made. Third, they discuss relevant options in light of international experience and evidence. Each of these chapters ends with a summary. Chapter six discusses lessons and implementation issues.

## **2 Health system pressures in Ireland**

### **2.1 Background**

**Between 2008 and 2011 Ireland's gross national product (GNP) fell by nearly 20 per cent** (CSO 2011, 2012a). A recent study estimates that, within the European Union (EU), only Latvia, Italy, Estonia and Greece have faced recessions of greater severity (Keegan et al 2012). Prior to 2008 Ireland had enjoyed one of the highest economic growth rates in Europe, and public expenditure rose rapidly between 2005 and 2008, increasing by nearly 40 per cent (Department of Public Expenditure and Reform 2012). Since 2008, however, there have been sharp increases in public debt, unemployment and outward migration.

**Due to the worsening economic outlook and the receipt of financial assistance from the EU and the IMF, large adjustments to the public finances are required in the coming years.** In 2008 and 2009 Ireland had several budgets to try and cope with the impact of the financial crisis and economic contraction, including the removal of €1 billion from the public budget for health in December 2009 (Thomas and Burke 2012). Following further deterioration in key indicators, in November 2010 Ireland accepted an EU-IMF Programme of Financial Support worth €85bn for the period 2010-2013. Between 2013 and 2015 a total adjustment of €8.6bn is needed, of which €5.55bn must come from cuts to public expenditure (Department of Finance 2011).

**Substantial cuts in public spending on health have already been made** (Thomas et al 2012b) (Table 2.1). Table 2.2 outlines the scale of savings in public expenditure on health that are still required. There is now very real concern about the meeting of cost reduction targets for 2012. In the last decade, overall levels of public spending on health have been in line with spending in other countries. However, the costs of delivery became higher in Ireland than in comparable countries and Ireland's particular mix of public funding, private health insurance (PHI) and out-of-pocket payments is unusual (discussed in greater detail in Chapter 4).



In spite of rapid increases in total health care expenditure in the 2000s, when the recession hit in 2008 Ireland still had poorly developed primary and community health services, with two thirds of the population paying the full out-of-pocket cost of primary care, and a model of care that favoured hospitals over community services. The adjustments that followed cuts in public expenditure had to take place against the backdrop of new political commitments to make improvements in primary and community care, in mental health and in some chronic disease programmes. In addition, the current Programme for Government contains commitments in relation to major changes to health care financing and entitlement structures (Government of Ireland 2011).

**Table 2.1 GNP and public and private spending on health, Ireland, 2006-2011**

		2006	2007	2008	2009	2010	2011
		(€m)	(€m)	(€m)	(€m)	(€m)	(€m)
<b>GNP*</b>		177,729	188,729	178,882	161,275	156,487	129,246
<b>Public**</b>		12,715	14,285	15,172	15,516	14,811	14,078
<b>Private*</b>	OOP	1,915	2,019	2,289	1,870	n/a	n/a
	Pre-paid	1,104	1,169	1,262	1,681	n/a	n/a
	Corporations	75	169	153	254	n/a	n/a
	<b>Total</b>	3,095	3,357	3,704	3,805	n/a	n/a

Source: \* Taken from CSO Database. \*\*Taken from Department of Health and Children, Health Statistics 2011(includes capital expenditure).

**Table 2.2 Required adjustments to public expenditure on health, Ireland, 2012-2014**

Year	Savings required (€m)
2012	-735
2013	-352
2014	-404
<b>Total</b>	<b>-1,491</b>

Source: Department of Health (2011). Comprehensive Review of Expenditure (September 2011).

Note: the figure for 2012 is made up of over €500 million in budget cuts and making good on previous cost-reduction commitments for hospitals of €200 million (Thomas et al 2012b).

## 2.2 Demographic change, health expenditure and health services

**Ireland has experienced and continues to experience significant population growth.** Although the population is ageing, what is unusual in Ireland in comparison to many other European countries is the overall rise in the size of the population, the continued rise despite the recession, and the projection of further rises. Table 2.3 shows that the population increased by around 11 per cent between 2005 and 2011 and that the rise in the population over 65 was nearly 20 per cent. Assuming stable fertility and moderating inward migration<sup>1</sup>, the projected population for 2016 is 5.094 million. Under this scenario, it is expected that the population over 65 will rise to 645,900 by 2016 (CSO 2008). It is now unlikely that the total population rise will be this rapid, since migration patterns have changed<sup>2</sup>. Based on recent census data, the population in 2016 is forecast to be around 4.8 million, with the population over 65 around 608,000 (Thomas et al 2012b).

**Table 2.3 Population (total and 65+), Ireland, 2005-2012**

	2005	2006	2007	2008	2009	2010	2011	2012	% change
Population	4,133.8	4,232.9	4,375.8	4,485.1	4,533.4	4,554.8	4,574.9	4,585.4	10.9
% change		2.4	3.4	2.5	1.1	0.5	0.4	0.2	
Population 65+	458.9	462.3	471.1	483.8	498.9	515.0	531.6	549.3	19.7
% change		0.7	1.9	2.7	3.1	3.2	3.2	3.3	

Source: CSO Databank (PEA01: Population Estimates (Persons in April) by Age Group, Sex and Year)

**It is useful to consider current public spending plans for health against the general rise in population and in the population over 65.** The current public expenditure estimates show a further fall in public spending on health from €13.644 billion in 2012 to €13.565 billion in 2013 and €13.359 billion in 2014 (Table 2.4).

<sup>1</sup> The 'M2F1' scenario used by the CSO assumes stable fertility rates and moderating inward migration over the period 2011-2041 (CSO 2008).

<sup>2</sup> Net emigration has been reported in 2012, but this is mainly in younger people who are relatively low users of health services. The fertility rate in Ireland is the highest in the EU, and presents further cost pressures.

Assuming level funding in 2015 and 2016, this would represent a fall of between 16 per cent and 24.5 per cent in spending per capita between 2009 and 2016. However, the fall relative to the population over 65 would be around 32 per cent.

**Table 2.4 Trends in public non-capital expenditure on health, Ireland, 2005-2011**

Year	2005	2006	2007	2008	2009	2010	2011
PHE (€m)	11,160	12,248	13,736	14,588	15,073	14,452	13,700
PHE per capita	2,688	2,889	3,166	3,299	3,380	3,233	3,055
PHE per 65+	24,319	26,175	29,188	30,291	30,451	28,365	26,140

Source: Department of Health

Note: PHE = public non-capital expenditure on health; PHE per 65+ = total public health expenditure divided by the number of residents over 65, not per capita spending per person over 65

**Population growth has not been matched by a rise in the capacity of the public health system in Ireland**, partly due to a deliberate decision to focus any additional resources on strengthening services outside hospitals and not to invest significantly in new hospital capacity (PA Consulting 2007). Data show that relative to the population and the population of older people, capacity and service availability have fallen. Table 2.5 shows the available hospital inpatient and day places in absolute terms and relative to the population. Table 2.6 shows the changing pattern of service delivery, trends in length of stay and changes in occupancy and delayed discharges. It demonstrates some efficiency gains over the recessionary period, despite falls in funding, as day cases have grown substantially and average length of stay continues to fall (Thomas et al 2012a).

**Table 2.5 Available inpatient beds and day places, Ireland, 2006-2009**

Year	2006	2007	2008	2009
Inpatient and day places	13,528	13,668	13,584	13,310
Inpatient and day beds per capita	0.003191	0.00315	0.003072	0.002985
Inpatient and day beds per capita 65+	0.028911	0.029044	0.028206	0.026889

Source: HSE (2012)

**Table 2.6 Trends in inpatient care, Ireland, 2007-2012**

Year	2007	2008	2009	2010	2011	Feb 2012	Change from 2007
Inpatient cases	611,467	599,910	594,360	588,431	588,623	n/a	-3.7%
Average length of stay	6.2	6.3	6.2	6.1	6.0	5.9	-4.8%
Day cases	583,369	641,974	675,162	734,967	804,274	n/a	37.9%
Occupancy	87.1	88.8	89.2	91.4	95.7	95.7	9.9%
Delayed discharges	611	702	n/a	n/a	774	783	26.7%

Source: HSE (2012)

**The effects of limited capacity and population growth are reflected in recent patterns in waiting lists and waiting times.** Table 2.7 shows total waiting lists for inpatients and day cases and the proportion waiting more than three months, both of which have started to rise following a period of improvement. A similar pattern can be seen in outpatient waiting lists, where numbers waiting are rising and average waiting times are rising, although there is a fall in numbers with very long waits.

**Table 2.7 Inpatient waiting lists and times, Ireland, 2008-2011**

	Jan 2008	Jan 2009	Dec 2009	Dec 2010	Dec 2011
Inpatients	17,711	18,556	16,834	15,490	15,753
% >3 months	60	51	45	51	57
Day case	25,063	24,792	28,957	35,092	44,049
% >3 months	55	43	38	36	45

Source: HSE (2012)

**The difficulty of discharging patients who no longer need hospital care is a constraint on effective use of hospital beds.** Community services and nursing homes provide support for those discharged from hospital. Table 2.8 shows trends in nursing home residents. The Fair Deal scheme now provides some public support for people in private nursing home care. The scheme cost around €994 million in 2011, up from €959 in 2009, but the picture is complicated by the winding down of the former public support scheme. Fair Deal includes both a grant element (means tested) and the option of a loan that is repayable after the death of the recipient. Uptake of the loan element has been low, and levels of repayment are consequently low.

There is some uncertainty about the exact level of nursing home care, but between 2006 and 2011 the numbers in nursing homes appear to have increased at a rate of around 3% per year (Wren et al 2012). The numbers for 2016 have been projected using the assumptions that the level of community care support does not decrease (or increase) and that age-standardised disability rates continue to fall. The pure demographic effects lead to a significant rise in the need for long-term care, and on the basis of current patterns of community provision this will require increased places in nursing homes at around 3% per year. The shift towards private provision of nursing home care, with a marked fall in the number of public nursing home beds, is only significant if there is a difference in the services provided in public and private homes and in their ability to deal with complex needs.

Home care packages and home help services support people with care needs in the community. Table 2.9 shows the trends in these services in terms of numbers of recipients and number of recipients relative to populations. Table 2.10 shows how home help hours have changed, again relative to the population. Although it is not possible to track those who receive both home help and home care package support, it is clear that there is a shift from reliance on the publicly provided service towards services provided privately with public funding.

**Table 2.8 Current and projected nursing home numbers, Ireland, 2006-2016**

	Numbers in residential long-term care (estimate)	Projected numbers in residential long-term care	Projected numbers in residential long-term care
	2006	2011	2016
<b>Male</b>			
65-69	591	675	785
70-74	901	943	1,105
75-79	1,447	1,660	1,887
80-84	1,843	2,150	2,635
85-89	1,576	2,126	2,802
90+	878	1,275	2,077
65+	7,236	8,828	11,290
<b>Female</b>			
65-69	502	564	657
70-74	1,067	1,087	1,243
75-79	2,109	2,153	2,287
80-84	3,780	3,935	4,239
85-89	4,239	5,142	5,773
90+	3,558	4,560	6,235
65+	15,255	17,441	20,435
<b>Total</b>			
65-69	1,093	1,239	1,441
70-74	1,967	2,030	2,348
75-79	3,557	3,813	4,175
80-84	5,623	6,084	6,874
85-89	5,815	7,269	8,575
90+	4,436	5,834	8,312
65+	22,491	26,269	31,725

Source: Wren et al (2012)

**Table 2.9 Home help (HH) and home care package (HCP) recipients, Ireland, 2006-2011**

Year	2006	2007	2008	2009	2010	Sep-11
HH	49,578	54,736	55,366	53,791	54,011	51,166
HH 65+	41,596	44,014	46,536	45,622	45,752	43,672
HH 65+ as % of population 65+	8.9%	9.2%	9.4%	8.9%	8.7%	8.0%
HCP	5,283	8,035	8,990	8,959	9,941	10,752
HCP 65+ as % of population 65+	5,283	8,035	8,990	8,959	9,941	10,752
HCP 65+ as % of population 65+	1.1%	1.6%	1.7%	1.6%	1.8%	1.8%

Source: Wren et al (2012) Data sourced from HSE Home Help Database. Note: Degree of overlap between home help and HCP package recipients not known. Recipients aged 65+ of home help in 2006 and of Home Care Packages in 2006 and 2007 estimated based on average share of recipients aged 65+ in subsequent years. Data are point in time: month or year end.

**Table 2.10 Total number of home help hours provided, Ireland, 2007-2011**

<b>Hours provided</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Total home help hours provided	12,351,087	12,643,677	11,970,323	11,680,516	11,092,436
<b>Hours provided per capita</b>	2.8	2.9	2.7	2.6	2.4
<b>Hours provided per capita aged 65+</b>	26.2	26.3	24.2	22.9	20.7

Source: HSE Monthly Performance Reports, Supplementary Data

### **2.3 Drivers of increased health care costs**

#### **Health care costs in Ireland have increased at a much faster rate than other**

**costs.** Empirical analyses of drivers of health care costs tend to focus on the impact of national income, population size (and distribution) and prices. Inflation in health care costs generally exceeds that for all items and between 2005 and 2011 health care costs in Ireland increased by over 20 per cent, while overall prices increased by approximately 10 per cent (Table 2.11). Some components of the health Consumer Price Index (CPI) decreased during this period (e.g. prescribed drugs), but many others have continued to increase strongly, particularly hospital charges, outpatient fees, doctors' fees and dental fees. Given the relatively large weight attached to hospital charges in the health component of the CPI, inflation in this item drives much of the overall increase.<sup>3</sup>

#### **Since 2005, Irish health care cost inflation has been the highest among EU15**

**countries, exceeded only by the Netherlands** (Table 2.12). In addition, in most other countries, inflation in general prices has exceeded that of health care items since 2005, whereas the opposite has been the case for Ireland.

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<sup>3</sup> The health component of the CPI has a weight of 4.6 per cent, while hospital charges have a weight of 2.1 per cent (CSO 2012b).

**Table 2.11 Consumer price index (all items, health items), Ireland, 2005-2011**

	Dec 2005	Dec 2011
<b>All items</b>	<b>100</b>	<b>109.5</b>
<b>Health items</b>	<b>100</b>	<b>121.4</b>
Medical products, appliances and equipment	100	99.2
Pharmaceutical products	100	94.5
Prescribed drugs	100	90.1
Other medicines	100	105.7
Other medical products	100	97.5
Therapeutic appliances and equipment	100	115.1
Out-patient services	100	123.5
Medical services	100	120.9
Doctors' fees	100	121.3
Alternative and complementary medicine	100	118.7
Dental services	100	128.6
Hospital services	100	147.3

Source: CSO (2012). StatBank (CPM09: Consumer Price Index by Detailed Sub Indices, Month and Statistic)

**Table 2.12 Harmonised index of consumer prices, EU15, April 2012 (2005=100)**

	All items	Health items	Difference
Ireland	108.9	123.3	14.4
Austria	116.4	114.2	-2.2
Belgium	118.5	102.3	-16.2
Denmark	116.6	110.2	-6.4
Germany	113.5	108.8	-4.7
Greece	124.0	115.8	-8.2
Spain	119.7	94.7	-25.0
France	114.0	113.5	-0.5
Italy	118.3	117.9	-0.4
Luxembourg	120.9	117.6	-3.3
Netherlands	113.8	125.5	11.7
Portugal	116.3	114.6	-1.7
Finland	117.6	109.0	-8.6
Sweden	113.7	110.7	-3.0
UK	122.9	123.1	0.2

Source: Eurostat (2012). Statistics Database

**In Ireland growth in the overall size of the population is a much more important health care cost driver than ageing.** Other drivers of increases in expenditure



typically include unmet need (in Ireland several areas have been identified including cancer care, several chronic diseases, mental health services and services for children) and raised expectations (which may lead to demand for unmet needs to be met). Developments in health technologies and new drugs do not directly drive higher costs but, insofar as previously untreatable diseases become treatable, or treatments become more effective, this can increase demand for services and funding. The effect of developments in technology (including drugs) on health care expenditure is usually much more significant than factors such as population ageing (Dormont et al 2006). Table 2.13 shows the growth in GP utilisation, which may reflect growing need due to demographic change and changed expectations. It should be noted that the data relate to the period before the full effects of the recession were felt, and this may also explain the increased utilisation by those who are not covered either by health insurance or medical cards. There is anecdotal evidence of attendances in this population starting to fall again.

**Table 2.13 Average number of GP consultations in 12 months prior to interview, persons aged 18 years and over, Ireland, 2007 and 2010**

	2007	2010
All	2.8	3.2
Medical card	5.3	5.2
Private insurance	2.4	2.6
Neither	1.5	1.9

Source: Central Statistics Office (2008, 2011), Quarterly National Household Survey (Health Status and Health Services Utilisation)

**Health systems in which access to health care is means-tested experience increased spending in recessions as incomes fall and more people become eligible for free or subsidised services.** In Ireland this mainly refers to medical cards (and GP visit cards) and entitlements to free or subsidised drugs. Analysis of data from the Irish Longitudinal Study of Ageing shows that free access to GP services increases

attendance by around 2 visits per year in those aged over 50.<sup>4</sup> Table 2.14 shows the rise in medical card and GP visit card entitlement. The proportion of the population with medical cards is now nearly 40 per cent. Ninety-one per cent of people in their seventies and 97 per cent of those aged over 80 have medical cards, and these age groups are increasing rapidly. In addition, these groups are more likely to be on multiple medications. Figures from TILDA show that 20 per cent of people aged over 50 are taking five or more medications, and nearly 50 per cent of those over 75 are taking five or more medications (Barrett et al 2011).

**Table 2.14 Medical card and GP visit card trends, Ireland, 2005-2012**

Year	2005	2006	2008	2008	2009	2010	2011	2012
Medical cards	1,155,727	1,221,695	1,276,178	1,352,120	1,478,560	1,615,809	1,694,063	1,787,839
% of population	28.0	28.9	29.2	30.1	32.6	35.5	37.0	39.0
GP visit cards	5,079	51,760	75,589	85,456	98,325	117,423	125,657	128,929
% population	0.1	1.2	1.7	1.9	2.2	2.6	2.7	2.8

Sources: PCRS (various years). Statistical Analysis of Claims and Payments; CSO (2012). StatBank. HSE (2012). Performance Report (April 2012).

Notes: Medical card and GP visit card figures for 2005-2011 are for December; 2012 figures are for April.

**Public expenditure on drugs rose very rapidly after 2000, but a number of measures have reversed this trend.** Table 2.15 shows the trend in expenditure for the three main community drugs schemes (CDS). Spending has fallen despite an increase in prescriptions funded (except on the DP Scheme, where the higher monthly limit has reduced the number funded), as a result of a number of measures to reduce the ex-factory price of drugs and the fees/mark-ups for dispensing and wholesaling functions. Further measures are in hand to reduce costs, including cuts in ex-factory prices and the introduction of a system of reference pricing and generic substitution.

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<sup>4</sup> Earlier work on the total adult population suggests that the effect of gaining a medical card is equivalent to approximately 1.1 to 1.3 extra GP visits per annum (Nolan 2008). Similarly, Thomas, Tyrrell et al (2012) estimate that the effect of gaining a medical card is now equivalent to 1 extra GP visit per year for those without a chronic condition and 2.1 extra visits for those with a chronic condition.

However, a recent comparison of ex-factory prices of the top ten pharmaceuticals by value in the GMS scheme shows that the ex-factory prices for these products are (with one exception) considerably higher in Ireland than in New Zealand, a similar-sized country (Table 2.16).

**Table 2.15 Expenditure on community drugs by scheme (€ millions), Ireland, 2008-2010**

Scheme	2008	2009	2010
GMS	1,129	1,246	1,220
DP	312	452	336
LTI	138	140	127

Source: PCRS (2011)

Note: published data for 2011 are not yet available.

**Table 2.16 Ireland vs New Zealand ex-factory pharmaceutical costs for the top 10 drugs by value in the GMS Scheme in 2010, July 2012**

Drug	Ratio Ireland: New Zealand
Atorvastatin	1.47
Salmeterol	1.41
Esomeprazole	n/a
Pregabalin	n/a
Lansoprazole	7.55
Omeprazole	18.05
Olanzapine	23.82
Clopidogrel	11.62
Rosuvastatin	n/a
Tiotropium bromide	0.93

Source: Author update of Table 4.4 in Gorecki et al (2012).

Notes: n/a: New Zealand does not subsidise drugs for three ATC classes above (esomeprazole, pregabalin and rosuvastatin). Prices are correct as of July 2012. New Zealand prices are converted to € using the June-July 2012 European Central Bank average exchange rate.

## 2.4 Recent cost containment measures and scope for further savings

**Given the labour intensity of the health sector, important measures to reduce costs in publicly funded health services include reductions in workforce pay, restrictions on recruitment, ceilings on staffing, redundancy schemes and incentivised early retirement.** Table 2.17 gives the total public health service employment by year. The revised plan is for this to fall to approximately 102,000 by the end of 2012. Further net reductions of around 6,500 are likely to be required in the 2013-2015 period. Staff reductions have achieved significant savings, but there are emerging issues, particularly regarding the resulting configuration of staff and the (in some cases) higher costs of agency staff (especially given the recent EU Directive on employment of temporary staff). There appears to be a cumulative effect of staff reductions from natural wastage and incentivised early retirement, so that the number of posts that have to be filled to ensure continued service delivery is likely to increase. There is also anecdotal evidence to suggest that the emerging staffing balance is damaging efficiency in some areas of service delivery. The plans for radical change in the organisation and delivery of services under the Programme for Government will require substantial reconfiguration of the workforce, some of which may be difficult under current procedures (Government of Ireland 2011). A further constraint is the EU Working Time Directive, which has particular consequences for junior doctors. It is also recognised that there are some service areas where there is a strong case for increased employment (for example, in mental health).

**Table 2.17 Total public health service employment, Ireland, 2005-2011**

Year	Dec 05	Dec 06	Dec 07	Dec 08	Dec 09	Dec 10	Dec 11
Total	101,978	106,273	111,505	111,025	109,753	107,972	104,392

Source: Department of Health (2011)

**The scope for savings in the early part of the recession was increased by two measures that reduced pay expenditure across the public service: the Pensions Related Deduction (commonly called the Pension Levy) and pay reductions.**

These measures largely offset the spending reductions required in 2009 and 2010, but did not provide any help in 2011 and 2012. While new (lower) entrant pay scales were introduced in 2011, limited recruitment at the moment has meant that this measure

will only achieve significant savings in the medium term. Under the 2010-2014 Public Service Agreement (also known as the Croke Park Agreement) staff have agreed to greater flexibility to help achieve efficiencies in exchange for a commitment to no further pay reductions and no compulsory redundancies (up to 2014). While there is some evidence of improved efficiency as a result of the agreement, this has not always been reflected in lower expenditure.

**Some saving and cost shifting has taken place by increasing user charges and reducing health care entitlements.** These include several reductions in the Drugs Payment Scheme limit, finally to €132 per month per family for 2012, which, along with the lower prices of some drugs has reduced the numbers eligible. A 50c co-payment per prescription item has also been introduced for medical card holders (subject to a monthly limit of €10 per family). The effect of this change on the use of prescribed drugs is not known and is the subject of a current study. The fee payable at hospital emergency departments by those who attend who do not have a medical card or a GP referral has been raised to €100. There have been some changes in entitlements to community services, including dentistry.

## **2.5 Summary**

This chapter has reviewed the main sources of pressure facing the health system in Ireland. Reduced public funding for health comes against a backdrop of population growth, large increases in the number of older people, increased pressure from growth in entitlements (one effect of recession in a means-tested system) and constraints on how, and how fast, changes can be made to the health workforce. Also, in spite of rapid growth in total spending on health care during the 2000s, Ireland still has poorly developed primary and community health services, with two-thirds of the population paying the full out-of-pocket cost of primary care, and a model of care delivery that favours hospitals over community-based care. An additional challenge relates to the growing need for long-term care which, if not met, will add to pressures on hospital capacity and efficiency.

The savings Ireland achieved in the early years of the recession came mainly from reductions in pay and related workforce measures. Other savings have come from changes in areas likely to have the least impact on service delivery, although measures that restrict access to health care have also been introduced. As a result, it is now much more difficult to make further savings from the same sources in the short term. To a significant extent, the challenge facing the Irish health system is not the absolute level of savings required but the speed at which these are to be achieved. Given the difficulty of making further large and rapid cuts to statutory resources while maintaining effective delivery of services, there is a risk that the longer term health reform goals set out in the Programme for Government will not be met. For example, the Programme for Government's welcome commitment to widening access to primary care conflicts with the possibility of increasing user charges in this sector.

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## 3 Changes to the level of statutory resources

### 3.1 Principles and objectives

This chapter looks at statutory resources for the health sector and considers potential changes to current policies in Ireland. Statutory resources are defined as payments that are pre-paid *and* mandatory, with both features critical to achieving policy objectives. In contrast, revenues which are voluntary and/or made at the point of service, have very different consequences in terms of key performance indicators. Pre-paid mandatory payments include the basket of indirect and direct taxes that contribute to general taxation, payroll taxes earmarked for health (often referred to as social insurance contributions), and the mandatory purchase of health insurance as used in the Dutch health system. Patient user charges, paid at or after the delivery of care, even though established by statute, are addressed in Chapter 4.

A number of principles underpin revenue raising in the health sector, including:

- Ensuring adequate levels of statutory resources in order to safeguard equitable access to health services
- Ensuring stability and predictability in revenue flows in order to sustain the delivery of services
- Fairness with respect to the burden of financing health services
- Efficiency and transparency
- Other relevant principles reflecting non-health concerns such as impact on wage competitiveness

**Adequate levels of statutory resources:** In broad terms, countries that have a greater dependence on mandatory contributions achieve greater equity of access to services of a given quantity and quality, and better financial protection for patients. Countries which rely to a larger extent on private health insurance (PHI) markets or out-of-pocket payments to fund health services tend to perform worse in terms of equity in financing, equity of access to services and financial protection. While far less of an



issue in high income countries, there is evidence to suggest that once out-of-pocket payments comprise more than 20% of all health spending, the incidence of patients facing financial difficulties when accessing services significantly increases (Ke et al 2010).

**Ensuring stability and predictability in revenues:** significant year-on-year variations in the level of statutory funds available for health services can be highly disruptive to the sustained delivery of health services of a given quality and desired level of access. The priority given to health in government budget allocations is an important mechanism through which the government can maintain revenue stability. Certain statutory sources are more sensitive to economic fluctuations than others and hence the composition or mix of statutory funds has consequences for the stability of health funding; hypothecating or earmarking revenues from a particular source is also an important policy issue and is discussed later in this chapter.

**Fairness in the funding of health services:** analysis of fairness in the way funds are raised for the health typically sector by looking at the degree of progressivity or regressivity<sup>5</sup>; research across OECD countries has found that public financing sources tend to have small positive redistributive effects (progressive) while private financing sources generally have larger negative redistributive effects (regressive) (van Doorslaer et al 1999). This research further concludes that direct taxes and social insurance contributions are both progressive, with out-of-pocket payments always, and private health insurance premiums often, regressive. Detailed analysis on this topic has also been conducted by researchers in Ireland and shows that, prior to the current crisis, statutory funding for health was marginally progressive (Smith 2010).

**Efficiency and transparency:** the collection of revenues incurs administrative costs

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<sup>5</sup> Both deviate from proportionality where the burden is shared equally across the population irrespective of ability to pay. Progressivity is when a larger burden falls on better-off households, while regressivity reflects a larger burden falling on lower income households. A more complete analysis of fairness would also consider the extent to which different groups in society benefit from the spending of statutory funds.

and it is incumbent on governments to perform this function as efficiently as possible. Some studies have compared relative administrative costs in private health insurance and statutory health systems, concluding that “[*Private*] insurers’ administrative costs generally fall between 10 and 25% of total premium income. In contrast, the administrative costs of statutory health systems are substantially lower at typically under 10%” (Thomson 2009a: 64). A separate analysis estimates that public insurance schemes in high-income OECD countries have average administrative costs of 4% with a maximum of 7%, and on average are three times higher in private health insurance schemes. The authors of this analysis make the point that lower costs are not necessarily better, as administrative efficiency depends on what the administration is achieving through its various activities to drive up efficiency across the health system (Nicolle 2012). There is little published evidence available on whether tax-financed systems are more administratively efficient in terms of collecting resources; in the context of Ireland, a major consideration would be that responsibility for collecting any new statutory revenues would fall within the ambit of existing institutions, and would not add significantly to current costs.

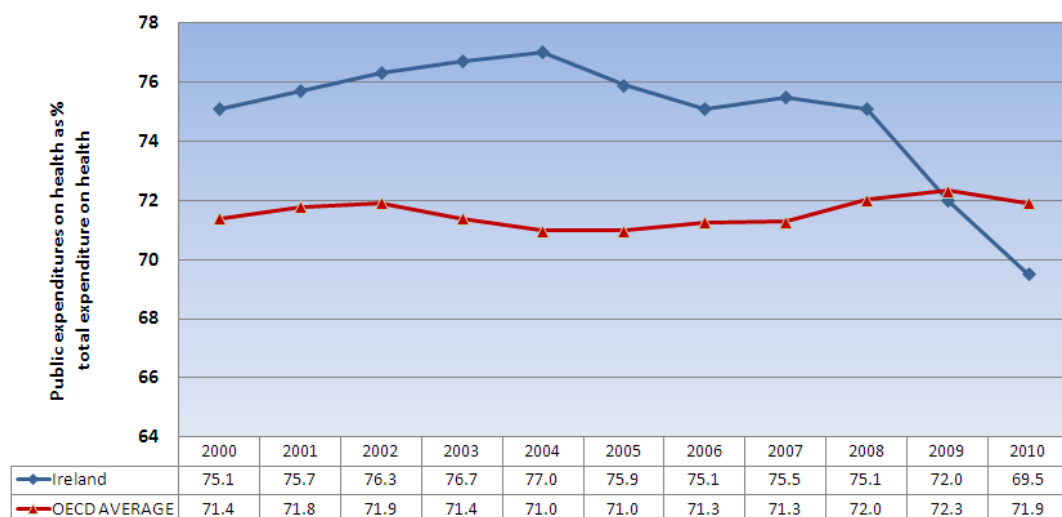
There is a connection between transparency and satisfaction with respect to how funds are spent and the likely acceptability of making contributions (Kutzin 2010); it may be argued that linking taxes to specific activities or interventions (e.g. earmarking tax revenues from cigarettes for preventive and curative health services) increases the acceptability or popular support for such taxes.

**Considerations beyond the health sector are also important**, particularly with respect to the effect of payroll taxes on wage competitiveness of labour. An overreliance on payroll taxes also raises concerns about the sustainability of revenue flows given how dependency ratios are changing in many countries, implying the need for payroll tax contribution rates to rise significantly even to simply maintain levels of spending.

### 3.2 The current situation in Ireland

**Statutory resources accounted for 69.6% of total health spending in 2010 having declined as a result of the crisis.** The proportion of total health spending coming from statutory sources in Ireland has reduced gradually from a high of 77% in 2004 to 69.6% in 2010 (see Figure 3.1). As reported by the OECD (2012)<sup>6</sup> and Irish researchers (Thomas et al 2012) and summarised in chapter 4, the faster decline after 2008 is the result of measures taken by the Government in response to the crisis. This reduction means that, for the first time in recent years, statutory funding in Ireland as a share of total health spending has fallen below the OECD average.

**Figure 3.1 Statutory health spending as % total health spending, Ireland and OECD, 2000-2010**



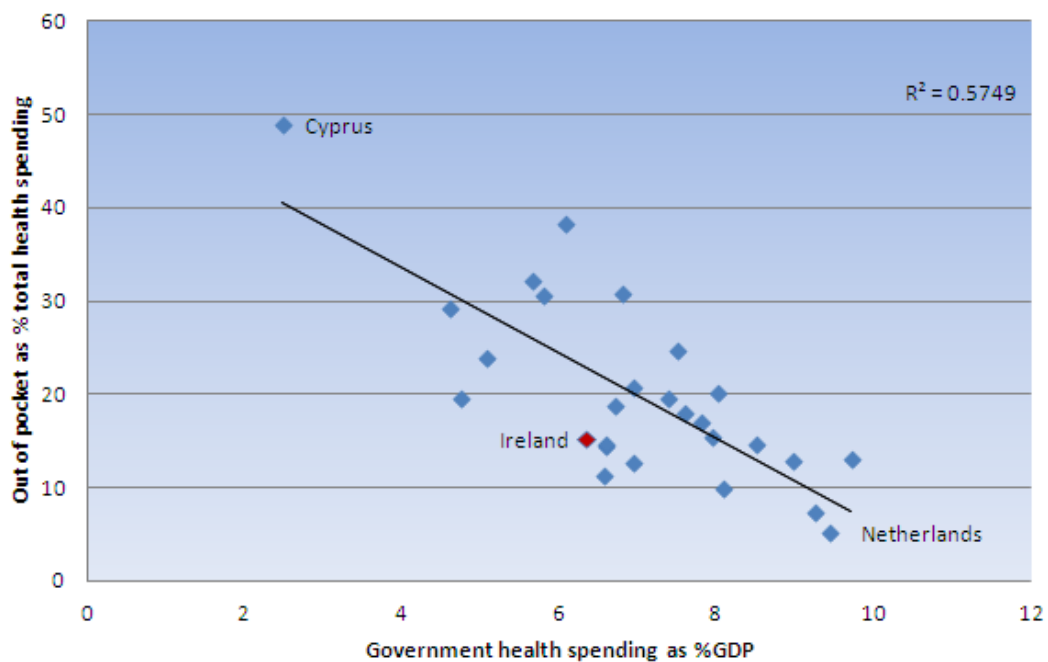
Source: Authors' calculations based on OECD (2012)

Private health spending has continued to increase year on year in real terms, with spending on private health insurance growing as a share of all private spending, accounting for 44.2% in 2010 (WHO 2012). Since 2010, however, the numbers of households purchasing private health insurance has started to decline (see chapter 4).

<sup>6</sup> <http://www.oecd.org/ireland/BriefingNoteIRELAND2012.pdf> [accessed 12 November 2012]

Statutory health spending as a % of GDP<sup>7</sup> indicates the dominance of this source of funding in the economy as a whole. It is another indicator closely linked to health system performance, in particular to reliance on private spending in the form of out-of-pocket payments at the point of service (see Figure 3.2), which itself is closely related to equity of access to health services.

**Figure 3.2 Relationship between statutory health spending as % of GDP and out-of-pocket payments, high-income countries, 2010<sup>8</sup>**



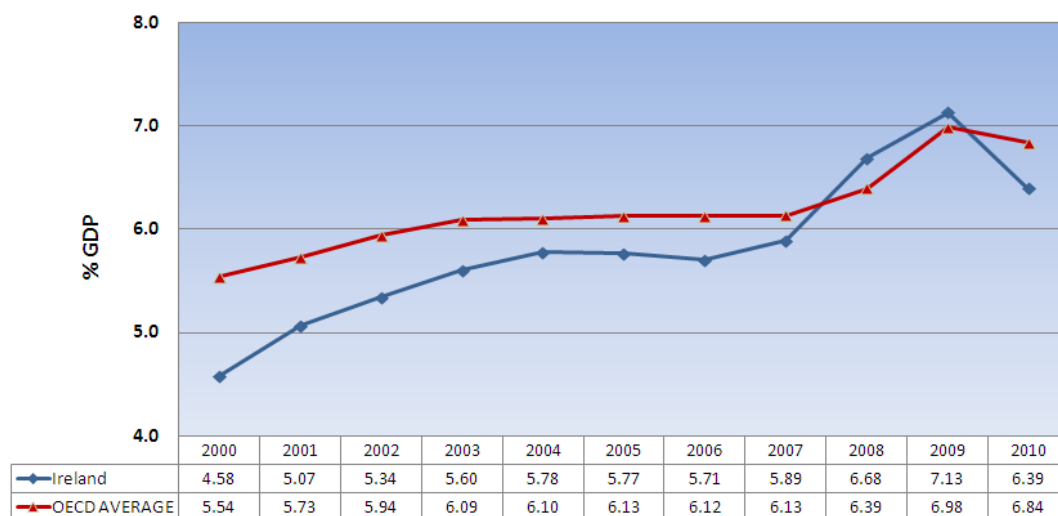
Source: Authors' calculations based on WHO (2012)

Figure 3.3 shows that, historically, Ireland has been below the OECD average on this indicator, until 2008 when it moved above; in 2010, however, it has once again fallen back below the average.

7 Given the large difference between GDP and GNP, the latter being far lower at approximately 80% of the GDP figure, many researchers use GNP as the denominator for such analysis. However, GDP is more widely used for international comparisons.

8 High-income countries as defined in WHO Databases. Note that this chart shows only out of pocket spending which accounts for around half of total private health spending; hence the difference with the amount implied in Figure 3.1.

**Figure 3.3 Statutory health spending as % GDP, Ireland and OECD, 2000-2010**



Source: Authors’ calculations based on OECD (2012)

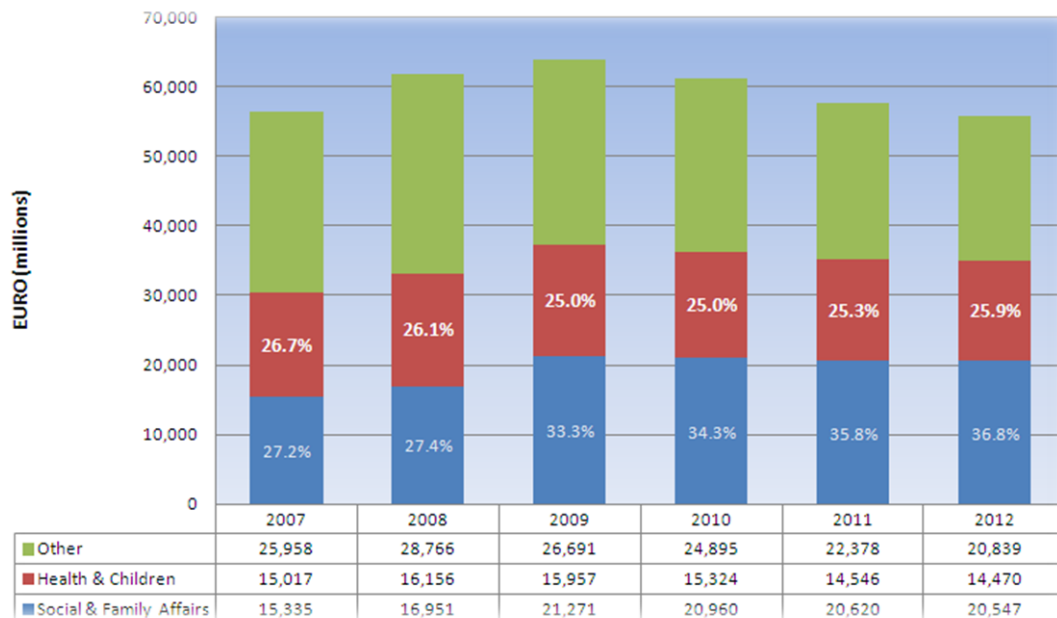
**Statistics** on overall health spending can be misleading. With respect to total health expenditures the OECD notes that “*In 2009 [total] health spending reached 9.5% of GDP in Ireland, on a par with the OECD average. The recent recession led to a big rise in [total] health spending as a share of GDP, as GDP began to fall sharply in the second half of 2008 and in 2009 while health spending continued to increase in 2008 and only came down slightly in 2009. As a result, the percentage of GDP devoted to [overall] health [spending] in Ireland increased from 7.7% in 2007, to 8.8% in 2008 and to 9.5% in 2009*” (OECD 2012: 1). This conclusion is also drawn in the Resilience Research Project (Thomas et al 2012) – that in the early stage of the crisis the health sector showed financial resilience by maintaining levels of statutory funding.

**Government budget allocations to health have remained stable in relative terms.**

Statutory funding for health has fallen in absolute terms, in terms of its dominance within the economy as a whole, and relative to private health spending. However, Figure 3.4 shows that health has more or less maintained its share of the shrinking overall budget available to government (26.7% in 2007 versus 25.9% in 2012). At the same time it is important to note how, during this period, demands on the public health service increased significantly, not least due to the sharp increase in the number

of people eligible for medical cards (30.1% of the population in 2008, rising to 39.0% in 2012, as noted in Table 2.14).

**Figure 3.4 Allocations to health as a % of the total government budget, Ireland, 2007-2012**



Source: Authors' calculations based on Department of Public Expenditure and Reform (2012)

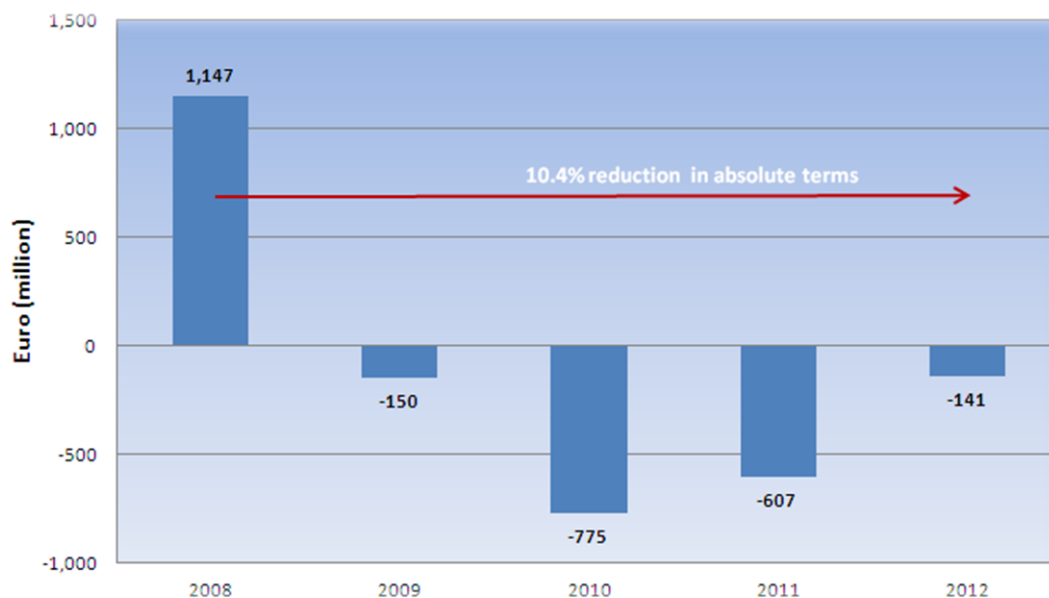
Note: Following the reorganisation of Ministries/Departments in 2011, estimates in the table for 2011 and 2012 include the full budget of the new Department of Children and Youth Affairs. Figures are based on initial budget allocations, rather than revised, audited estimates of actual spend.

Furthermore, health spending should not be looked at in isolation from broader social spending, as additional revenue from social support may offset increased charges for medicines or consultations. In Ireland overall, social spending has increased as a share of total spending from 53.9% of total government spending in 2007 to 62.7% in 2012. This has been driven largely by the automatic stabiliser effect of unemployment benefits; the level of unemployment increased dramatically from 4.8% at the end of 2007 to 14.8% in July 2012.

**Statutory health spending has fallen by 10.4% in absolute terms since the crisis escalated in 2008.** The actual decrease in health expenditures was higher in 2011 than the nominal decrease indicated in government budget allocations through the Health Group of Votes as substantial additional savings had to be made to meet revised

Government expenditure targets during the year. Figure 3.5 shows changes in actual spending with Ireland now in its fourth year of reductions in absolute terms.

**Figure 3.5 Changes in actual government health spending, Ireland, 2008-2012<sup>9</sup>**



Source: Department of Public Expenditure and Reform (2012)

Overall, while the data show some stability in terms of relative allocations to the sector, the health sector has suffered unprecedented cuts in real terms. A detailed timeline of changes to the budget and summary of how and where these cuts were made is documented in the Resilience Research Project (Thomas et al 2012) and summarised in chapters 4 and 5.

In 2012 the Health Service Executive, in accordance with its National Service Plan, has planned a reduction of expenditure of €750m to meet cost pressures and commitments under the Programme for Government, far higher than the provisional amount indicated in Figure 3.5. As indicated in Table 2.2, substantial additional reductions are expected in budgets for 2013 and 2014 (HSE 2011).

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<sup>9</sup> Note that the figure for 2012 is an estimate.

## **How progressive is statutory funding for the health sector?**

### **Prior to the crisis statutory funding for health was marginally progressive.**

Detailed analysis of the extent to which health care financing in Ireland is equitable has found income tax and social insurance contributions<sup>10</sup> were progressive in 1987/88, 1999/2000 and 2004/05 but that the ceiling on contributions dampens progressivity and helps to explain why they are not as progressive as income tax (Smith 2010). The research found indirect taxes<sup>11</sup> to be regressive in 1987/88 and 1999/2000; because indirect taxes account for a substantial share of government revenue, their regressivity almost fully offsets the progressivity of income tax. Total taxes were found to be slightly progressive in 1987/88 (0.05) and 1999/2000 (0.04) (Smith 2010).

**During the crisis statutory funding has become more progressive, albeit in the context of greater overall reliance on voluntary payments.** In terms of direct tax revenues, the Universal Social Charge (USC) was introduced on 1<sup>st</sup> January 2011 replacing both the Income Levy<sup>12</sup> and the Health Levy<sup>13</sup>; the USC contributed 22.5% of income taxes in 2011 and is seen by many as contributing to the turnaround in revenue receipts (Figure 3.6). Also in 2011 the ceiling on PRSI of €75,036 was abolished<sup>14</sup>. At the end of August 2012, the Department of Finance reported that in year-on-year terms taxes were up almost €1.6bn (7.7%), and stand 1.7% ahead of target with particularly strong growth in direct tax revenues (Department of Finance 2012).<sup>15</sup>

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10 Note that this refers to PRSI (Pay Related Social Insurance) contributions which are non-earmarked.

11 The author analyses only VAT revenues, by far the largest source of indirect taxes.

12 The Income Levy was a tax on gross income, calculated separately from income tax, and charged before deductions such as capital allowances or contributions to pensions. It was effectively a form of income tax.

13 The Health Levy was charged at 4% on all earnings above €26000 up to €75,036 and 5% on earnings over €75,036 and was effectively an additional income tax; it is not clear that revenues were earmarked for the health sector despite its name.

14 Taken from the section entitled "*How much social insurance (PRSI) must I pay?*"

[http://www.citizensinformation.ie/en/social\\_welfare/irish\\_social\\_welfare\\_system/social\\_insurance\\_prsi/social\\_insurance\\_classes.html](http://www.citizensinformation.ie/en/social_welfare/irish_social_welfare_system/social_insurance_prsi/social_insurance_classes.html) [accessed 12 November 2012]

15 See newspaper report: <http://www.rte.ie/news/2012/0904/tax-receipts-1-7-ahead-of-target.html> [accessed 12 November 2012]

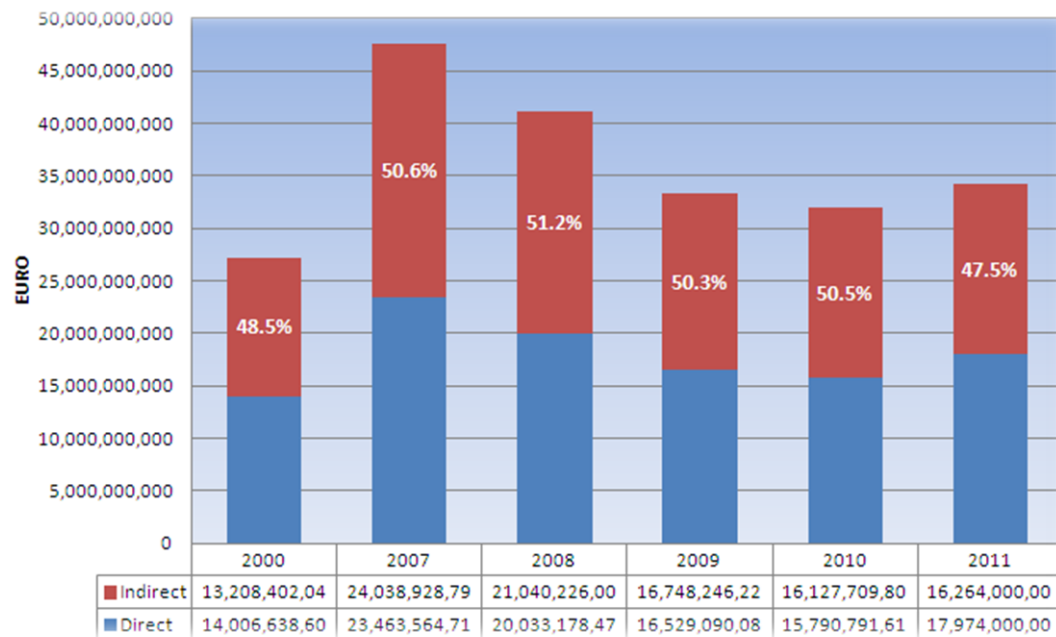


The analysis referred to earlier (Smith 2010) concluded that indirect taxes were regressive in 1987/88 and in 1999/2000; more recent analysis is not available, but there has been no radical change to indirect taxation policy or its implementation since the 1980s. We can hence look at whether the balance between indirect and direct taxes has changed more recently, given that greater reliance on indirect taxes will increase regressivity in overall statutory sources.

**Government revenues became increasingly reliant on indirect taxation after 2000, although this weakened in 2011 to below the level in 2000** (Figure 3.6).

Overall, the two policy measures introduced in 2011 and the stronger direct tax revenue performance in 2012, and the increase in the USC exemption limit in 2012 all suggest greater progressivity in direct taxation and, by extension, greater fairness in statutory funding for the health sector, as some Irish researchers also claim (Callan et al 2011). At the same time, however, statutory funding has become less dominant overall as the government has made cuts designed to reduce public sector debt. Figure 3.1 showed how statutory spending fell to less than 70% of the total in 2010. Figure 3.7 shows how the various statutory sources have been hit by the crisis; between 2007 and 2011, indirect tax revenues fell by 67.7% in absolute terms, with direct tax revenues falling by 76.6%.

**Figure 3.6 Direct and indirect taxes as a % of total net government revenue, Ireland, 2000 and 2007-2011**

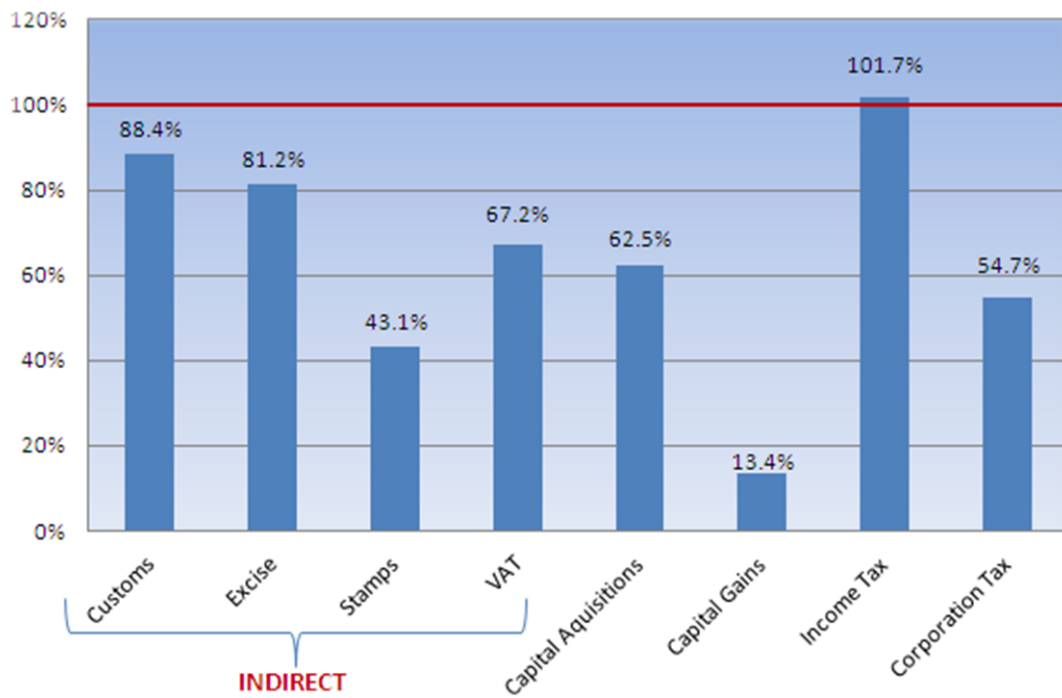


Source: Irish Tax and Customs (2010, 2011)<sup>16</sup>

**Sin taxes currently play a limited role within statutory revenues.** In 2011 indirect net tax receipts from alcohol and tobacco amounted to around 12% of net indirect tax revenues and 5.7% of total net revenues (Figure 3.7 and Figure 3.8). In their review of potential revenue sources for a system of social health insurance, Thomas et al (2010) argue that it would be reasonable to earmark this revenue for the health sector, given that the harmful consumption of alcohol and tobacco are two of the risk factors closely associated with the development of non-communicable diseases. Moreover, there are strong arguments for increasing these taxes on health grounds alone and, given that demand is relatively price inelastic it is most likely the case that both consumption would reduce as well as revenues increase in response to further tax rises.

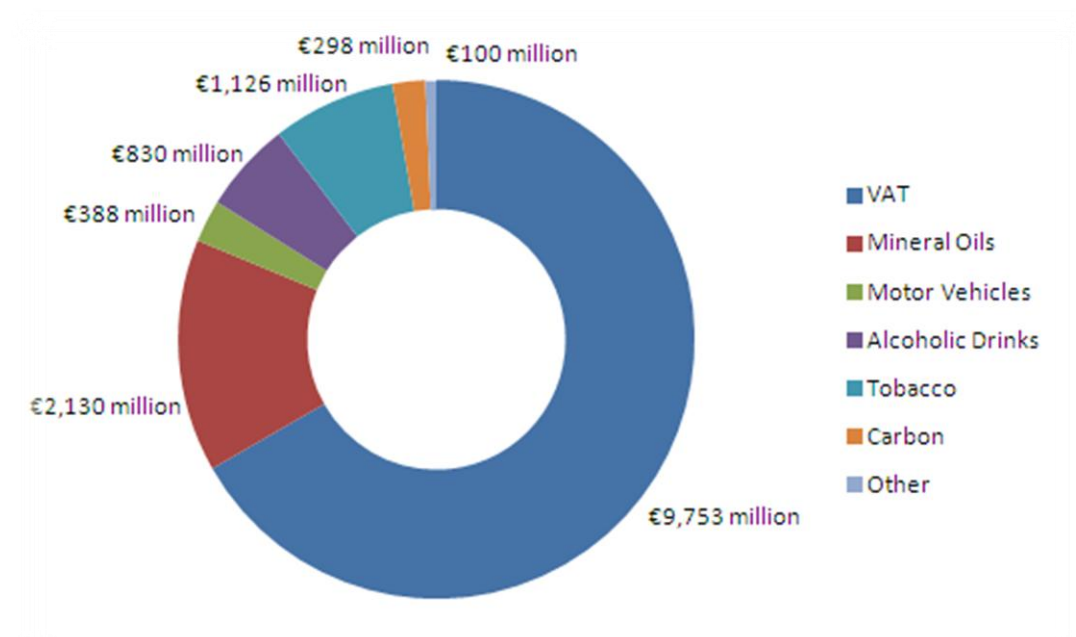
<sup>16</sup> There are eight major sources of government revenue reported in official documentation. The author categorised these into direct and indirect sources, following convention, as follows: direct sources (Income tax, Capital Acquisitions Tax, Capital Gains Tax, Corporation Tax), and indirect sources (VAT, Customs, Excise, Stamp Duty, and separately Customs Duties on Agricultural Products).

**Figure 3.7 Levels of tax revenues in 2011 compared to 2007 levels (2007 = 100%)**



Source: Irish Tax and Customs (2010, 2011)

**Figure 3.8 Indirect tax receipts including sin taxes, Ireland, 2011<sup>17</sup>**



Source: Irish Tax and Customs (2011)

### **3.3 Policy options: international experience and evidence**

In August 2012 government spending on health was overrunning by around €259 million for the year, and for this reason has been singled out for attention under the EU-IMF Economic Adjustment Programme for Ireland, despite the substantial reductions in spending absorbed over the past three years. There is now considerable political pressure on the health sector to reduce levels of statutory spending further. The Department of Health's response has been to announce further cuts at the end of August 2012, including reductions in the use of agency staff, a cut in overtime and

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<sup>17</sup> Revenue from stamps and customs are excluded from this chart, which explains the slight difference with Figure 3.6.

some home help care, and the removal of entitlements for weight loss and anti-cholesterol drugs for 50,000 families currently holding medical cards<sup>18</sup>.

Findings from the Resilience Project show that initial budget reductions were managed relatively well, in particular through the Value for Money initiative. The project report notes that savings for this period amounted to €687 million and substantially exceeded the original target, even though medical cards and total hospital discharges per year rose significantly (Thomas et al 2012). Chapters 4 and 5 outline in detail the adjustments made in the system to deal with budget reductions. The following paragraphs review policy options for statutory revenues in Ireland, and do so in the context of emerging trends in other European countries.

There are several options now facing the Irish Government. **First**, to continue with budget reductions as expected under the Programme for Government (Government of Ireland 2011). A **second** option is to work within the existing fiscal framework, but to put the case for limiting further reductions to the health budget, for example the limits to absorbing further cuts through efficiency gains in the short term, and hence potentially damaging access to services. Some form of earmarking or formula to stabilise general revenue allocations could play a role here. **Third**, a new source of statutory revenue could be introduced, for example a payroll tax earmarked for health to supplement general revenues. Additional sin taxes may also be considered, although as noted above, the primary rationale for these new taxes is to meet public health objectives rather than to raise revenue. Mandatory purchase of health insurance is also a form of statutory revenue, and is firmly on the agenda of the Irish Government. However, this issue is not discussed in detail here, as the introduction of such a system would require a fundamental overhaul of the use of all statutory funds for health, and requires a detailed analysis beyond the scope of this ‘rapid response’. The following paragraphs discuss some of the other options in more detail.

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18 Some of these provisions were subsequently reversed. See <http://www.irishtimes.com/newspaper/breaking/2012/0905/breaking2.html> [accessed 12 November 2012]

## **Payroll taxes earmarked for health**

**Payroll taxes earmarked for health are common across high income countries.** Of the 27 countries in the European Union, at least 18 have taxes earmarked specifically for health; these taxes are mainly levied on wages. Table 3.1 shows the prevailing contribution rates in many of those countries for 2007; several countries have made changes since 2007, including Germany, Hungary and Latvia. The table also notes whether or not there is a ceiling on contributions, which limits progressivity, and the extent to which employers and employees share the contribution. In terms of the latter, with the exception of Poland and Latvia, the employer is generally responsible for at least 50% of the total contribution. Increasingly, policy makers are making changes to contribution rates on only one side of the equation, typically employees, in an attempt to raise more revenue without increasing labour costs.

**In most of these countries general tax revenues play an increasingly important role.** Often, a transfer is made from the general budget to the health insurance fund as a contribution on behalf of the non-working population. Two broad socio-economic trends have led many countries to gradually increase reliance on general tax revenues alongside revenues from payroll taxes for health in order to fund the health system: economic policy that aims to reduce the tax burden on labour, in particular on employer contributions, as part of an economic competitiveness agenda; and upward pressure on payroll tax contribution rates due to changing dependency ratios which makes exclusive reliance on this source unsustainable.

**Table 3.1 Contribution rates, ceilings and distribution between employers and employees, EU27, 2007**

Country	Contribution rate	Ceiling on contributions	Ratio of contributions (ER:EE)
AT	Varies, mainly 7.5%	Yes	Varies, roughly 50:50
BE	EE/ER: 37.8%; lower rates for CS (7.3%) and SE (19.6%)	EE/ER, CS: no; SE: yes	65.5:34.5; CS: 52:48
BG	6%	No	70:30 (50:50 in 2009)
CY	EE/ER: 12.6%; lower rates for SE (11.6%) and V (10%)	EE/ER: yes	50:50
CZ	EE/ER: 13.5%; for SE only levied on 50% of net income	EE/ER: no; SE: yes	66:33
EE	13%	No	100:0
FR	13.5% (lower ER contribution on low wages); Contribution Sociale Generale: 5.25% (3.95% on benefits and pensions)	No	94:6
DE	Varies, average almost 15%; uniform rate from 2009	Yes	50:50
EL	Varies, mainly 6.45%	Yes	66:33
HU	15% + ER pays monthly flat rate (€7.72) per employee (pro rata)	No	73:27 <sup>19</sup>
LV	Part of personal income tax earmarked for health	No	0:100
LT	3% (ER) and 30% (EE, SE) of personal income tax earmarked for health; F, SMU: 3.5% and 1.5% respectively of minimum wage; other: 10% of average salary	No	100:0
LU	5.4%	Yes	50:50
NL	EE/ER: 6.5%; SE: 4.4%; P: 6.5% of the general old-age pension, 4.4% of any extra pension; aged 18+ pay a nominal premium set by insurers (average €1,106 pa)	Yes	50:50
PL	9%	No	0:100
RO	13.5%	No	52:48
SK	EE/ER, SE: 14% (7% for disabled people)	Yes	71:29
SI	EE/ER, SE: 12.92% of gross wage or sickness benefit; F: 6.36% of pension/disability insurance base	No	51:49

Source: Reproduced from Thomson (2009b)

Notes: CS = civil servants; EE = employee; ER = employer; F = farmers; P = pensioners; SE = self-employed; SMU = small land users; V = voluntary insured

<sup>19</sup> This ratio has now changed radically to a 2% contribution by employers and 6% by employees.

In **Hungary**, for example, the payroll contribution rate has steadily decreased over the past 17 years, while at the same time government budget transfers have increased contributions on behalf of non-contributors but also to compensate for the loss of payroll tax revenue (see Figure 3.9). In 2010 general government budget allocations became the dominant statutory source for the first time, accounting for over 60% in 2011, in part due to the lowering of the employer payroll contribution rate to only 2%.

In **France** the General Scheme (CNAMTS), the main social health insurance scheme, which covers around 87% of the population (Chevreul et al 2010), has increasingly relied on government budget transfers to fund health care, notably from the Generalised Social Contribution, an earmarked income tax introduced in 1990. This source comprised 37.6% of revenues to the General Scheme in 2007, with a further 13% coming from other state subsidies and earmarked sin taxes, making non-payroll taxes the dominant statutory source.

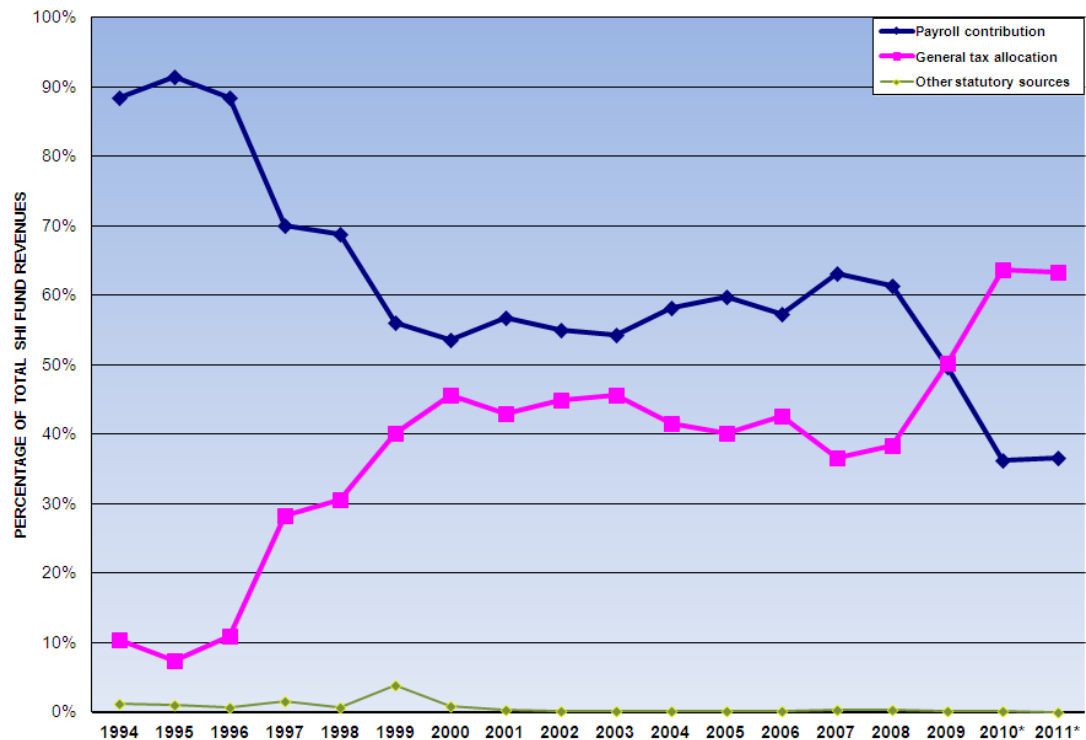
In **Germany**, in addition to the increased use of government budget transfers to supplement payroll tax revenues, new legislation at the end of 2010 led to higher insurance contribution rates for employees from 7.9 to 8.3 percent of gross salary, with the employers' contribution remaining at 7.3 percent; any future increases will be paid only by employees, which is consistent with concerns about the competitiveness of labour<sup>20</sup>.

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<sup>20</sup><http://www.dw.de/dw/article/9799/0,,6223367,00.html> [accessed 12 November 2012]



**Figure 3.9 Social health insurance in Hungary is increasingly reliant on general tax funding**



Source: Szigeti and Evetovits (2011)

### **Earmarking statutory revenues**

**New income from earmarked payroll taxes may be offset by reductions in budget transfers.** This is the case in many of the predominantly general tax funded health systems which have introduced earmarked payroll taxes for health over the past two decades. In these systems governments more than offset new revenues from payroll taxes with lower budget allocations to the health sector (Kutzin 2010). While this experience is largely from middle-income countries, it is nevertheless worth noting. The starting point matters; the rationale for using greater general tax funding to complement earmarked payroll taxes is clear (i.e. on behalf of non-contributors), but the opposite (i.e. using earmarked payroll taxes to complement general tax funding) is less so.

**Perhaps the most important question to ask in terms of policy is whether the basis for calculating general tax allocations to health would change were a**

**payroll tax to be introduced, and if so how?** Payroll taxes constitute a narrow revenue base compared to general tax revenues and display pro-cyclical fluctuations which need to be compensated for to ensure adequacy and stability of statutory funding for health. In many European countries general budget transfers are made on behalf of the non-contributing population, to broaden the revenue base for health. Contributions made on behalf of the unemployed provide a counter-cyclical dimension to health financing. As noted in chapter 2, in Ireland there is a counter-cyclical response through the issuing of medical cards to those whose income falls below a certain level. However, this is ineffective, if not problematic, given that there is no link with funding.

In addition to accounting for the unemployed, general budget revenues for health can be calculated in a manner that addresses the need for counter-cyclical health spending. For example in Lithuania, mechanisms have been put in place to ensure that government budget transfers automatically increase if revenues from earmarked payroll contributions fall; this maintains a stable revenue stream for the health insurance fund, with the underlying calculation based on average salaries in the previous two fiscal years.

In contrast there is no explicit methodology for calculating government budget transfers to the health insurance fund in Hungary, and the health sector tends to be given a low priority, leaving it vulnerable to government budget cuts despite significant earmarking through the payroll tax component (government budget allocations fell by 2 percentage points between 2003 and 2010). In Estonia, the health insurance fund is obliged to accumulate reserves in order to build up a buffer for periods when payroll tax income falls. This latter approach to counter-cyclical health financing reduces expenditure inflation during periods of revenue growth and offers stability during recession, reducing vulnerability to government budget allocation decisions.

**The earmarking inherent in payroll taxes for health can lead to greater stability in statutory funding if counter-cyclical measures are incorporated into the design.** The picture is complex, however, and the evidence is not conclusive.

Allocations to health over the past decade in four high-income countries (Denmark, Portugal, Spain and the United Kingdom) entirely reliant on general taxes for statutory funding show a high degree of stability, and where there are fluctuations these tend to be in a positive direction (i.e. an increase in allocations to health). A similarly strong commitment to stable revenues for health is not observed in eastern European countries, where earmarking is therefore a favoured alternative in political debates over government budget allocations. Earmarking may provide greater stability in statutory funding for health in some contexts, but it cannot completely remove the health sector's exposure to economic fluctuations and related political decisions over sectoral allocations. Some researchers in Ireland believe that earmarking through the introduction of payroll taxes would be a positive move (Thomas 2010).

Depending on broader tax policy considerations, revenues from an earmarked payroll tax for health may be considered supplementary to budget allocations, or alternatively the major source of funding with general taxes playing a complementary role. In either case, the basis for calculating the amount of the general revenue contribution is critical in terms of ensuring adequacy and stability in statutory sources for the health sector.

**Earmarking can also be introduced within the current set of statutory resources** i.e. without introducing an earmarked payroll tax for health, as is the case in Denmark. In Ireland some form of earmarking of statutory resources could be considered, or rather the establishment of a formula to determine budget allocations; one justification for this link is the sharp increase in demands on the sector as the number of medical card holders has sharply increased (Figure 4.2), and some link between government allocations and this growing demand would make sense in order to safeguard services for the population.

## **New taxes on unhealthy consumption**

A number of countries are considering the potential for raising new taxes on unhealthy consumption, particularly on foods and drinks, although it needs to be stressed that the primary objective is to reduce consumption, rather than raise revenues. Taxes on alcohol and tobacco are long-standing in Ireland, and excise rates are some of the highest in the OECD. The focus on high fat foods and sugary soft drinks is driven by the clear evidence of risk factors underlying the growing burden of non-communicable diseases, and studies that show that using tax policy is one of the most cost-effective policy interventions (Table 3.2). Table 3.3 includes details of measures taken in Denmark and Hungary, two countries which have introduced a comprehensive set of measures.

It is early days in terms of understanding the revenue likely to be generated from these new taxes, and it needs to be stressed that this should not be the primary motivation behind such taxes. These taxes are in themselves a public health intervention sending price signals to consumers with the aim of reducing demand; from this perspective the higher the level of taxation the better, which is not necessarily the case from a revenue raising perspective. Figure 3.10 shows data from the United Kingdom, where tobacco revenues have gradually risen and remained steady as taxes have increased, and represent around 1% of government revenues.

Whether or not new revenues from such taxes would be earmarked for the health sector is a separate policy decision from whether or not to introduce the tax itself. In Hungary new revenues are earmarked, but once again some offsetting is taking place in terms of other budgetary allocations.

**Table 3.2 Interventions to tackle non-communicable disease risk factors: identifying best buys**

Risk factor (DALYs, in millions; % global burden) <sup>a</sup>	Interventions / actions  (* core set of 'best buys', others are 'good buys')	Avoidable burden (DALYs averted, millions)	Cost-effectiveness <sup>b</sup> (US\$ per DALY prevented) [Very = < GDP per person; Quite = < 3* GDP per person Less = >3* GDP per person]	Implementation cost (US\$ per capita) [Very low = < US\$0.50; Quite low = < US\$ 1 Higher = > US\$ 1]	Feasibility (health system constraints)
<b>Tobacco use</b> (> 50m DALYs; 3.7% global burden)	<b>Protect people from tobacco smoke *</b> <b>Warn about the dangers of tobacco *</b> <b>Enforce bans on tobacco advertising *</b> <b>Raise taxes on tobacco *</b>	Combined effect: 25-30 m DALYs averted  (> 50% tobacco burden)	Very cost-effective	Very low cost	Highly feasible; strong framework (Framework Convention on Tobacco Control)
	Offer counselling to smokers		Quite cost-effective	Quite low cost	Feasible in primary care
<b>Alcohol use</b> (> 50m DALYs; 4.5% global burden)	<b>Restrict access to retailed alcohol *</b> <b>Enforce bans on alcohol advertising *</b> <b>Raise taxes on alcohol *</b>	Combined effect: 5-10 m DALYs averted  (10-20% alcohol burden)	Very cost-effective	Very low cost	Highly feasible
	Enforce drink driving laws (breath-testing) Offer counselling to drinkers		Quite cost-effective	Quite low cost	Intersectoral action Feasible in primary care
<b>Unhealthy diet</b> (>15m DALYs; >1% global burden) <sup>c</sup>	<b>Reduce salt intake in food *</b> <b>Enforce ban on trans fat in food *</b>	Effect of salt reduction: 5 m DALYs averted	Very cost-effective	Very low cost	Highly feasible
	Restrict food marketing Promote public awareness about diet <sup>d</sup>	Other interventions: Not yet established globally	Very cost-effective (but more studies needed)	Very low cost	Highly feasible
	Introduce food taxes and subsidies Offer counselling in primary care <sup>d</sup> Provide health education in worksites <sup>d</sup> Promote healthy eating in schools <sup>d</sup>		Quite cost-effective  Not cost-effective	Higher cost	Feasible in primary care Highly feasible
<b>Physical inactivity</b> (> 30m DALYs; 2.1% global burden)	Promote physical activity (mass media) <sup>d</sup>	Not yet established globally	Very cost-effective (but more studies needed)	Very low cost	Highly feasible
	Promote physical activity (communities) Support active transport strategies Offer counselling in primary care <sup>d</sup>		Not established	Not established	Intersectoral action
	Promote physical activity in worksites <sup>d</sup> Promote physical activity in schools <sup>d</sup>		Quite cost-effective  Not cost-effective	Higher cost	Feasible in primary care Highly feasible

Source: Reproduced from WHO (2010) page 56

<sup>a</sup> DALYs (or disability-adjusted life years) are widely used as a measure of premature mortality and ill health - one DALY can be thought of as one lost year of healthy life.

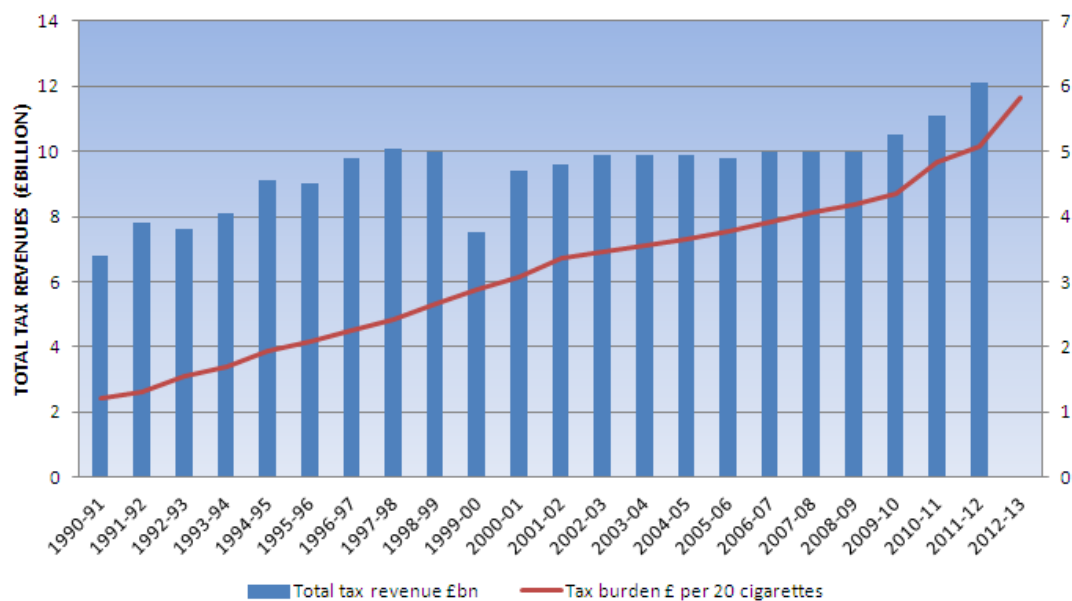
<sup>b</sup> See Annex 1 for a checklist of intervention cost-effectiveness. <sup>c</sup> Low fruit and vegetable intake only. <sup>d</sup> Combined intervention covering both diet and physical activity (counselling in primary care; school-based intervention; work site intervention); the independent effect of these interventions - on diet or physical activity alone - has not yet been established at the global level.

**Table 3.3 New taxes on unhealthy consumption in the European Union**

Country	Measures taken	Expected revenues
<b>Denmark (October 2011)</b>	Levy of €2.41 per kilo of saturated fat, when reaches more than 2.3% of content of a particular food (October 2011)	Unavailable
<b>Hungary (September 2011)</b>	€0.016 per litre of soft drinks €0.33 per kilo for pre-packaged sweetened products, €0.67 per kilo for salty snack €0.84 per litre of energy drinks	€74-170m per annum Earmarked for health system
<b>France (planned 2012)</b>	€0.036 per litre of sweetened drinks	€150m per annum
<b>Romania, Finland, UK</b>	Specific measures under development	Romania: €1bn per annum

Source: Authors' research (Jowett 2011)

**Figure 3.10 Taxing tobacco in the United Kingdom, 1990/91-2012/13**



Source: Authors' calculations from Tobacco Manufacturers Association (2012)

In Ireland, a Special Action Group on Obesity was established in 2011 and is considering the introduction of a Sugar Sweetened Drinks tax. A Health Impact Assessment Report including estimates of the cost of obesity to the health system, and estimates of revenues, is expected to be finalised in October 2012.

## **Savings through efficiencies as a source of additional funds**

It is important to note that every euro saved through efficiency gains is the equivalent of an additional euro allocated to the health sector. It goes without saying that all health systems need to continually look for more efficient ways of providing health services, but it is questionable whether further savings can be made through efficiencies in Ireland in the short-term without damaging access to priority health services. Moreover, it is important to differentiate true efficiency savings, whereby the same or more is achieved with less, from crude cuts. Chapter 5 considers this issue in detail.

### **3.4 Summary**

This chapter has reviewed statutory sources of funding for the health sector in Ireland. Changes to current policy should be judged against a number of objectives, including ensuring adequate funding for the sector, stability in revenue flows, fairness in the burden of making contributions, efficiency and transparency, and concerns beyond the health sector such as the wage competitiveness of labour.

The health sector in Ireland is currently in its fourth year of government budget reductions, with further cuts expected in the coming year, in line with continued fiscal tightening. Although it has so far maintained its share of a shrinking government budget, the demands upon it have risen dramatically as the number of medical card holders has grown in response to sharply increased unemployment. The share of expenditures coming from statutory sources has fallen below the OECD average for the first time in over a decade. While there is some evidence to suggest that fairness has increased in the way that statutory resources are raised, this has more than likely been offset by an increased reliance on private spending overall.

There are a number of policy options with respect to changing the level of statutory resources. The **first** is to continue to absorb expected budget reductions and make the necessary adjustments. However, there are serious concerns whether this can be achieved without damaging access to necessary services for certain groups of people,

unless further corrections are made to the significant imbalances within the health sector (particularly the size of provider salaries, noted in chapter 5).

A **second** option is to put the case for limiting further reductions to the health budget while planned reforms are implemented. This could include the establishment of a mechanism to reflect the sharply increased demands on the sector, which would help to maintain adequacy and a greater degree of stability in revenues.

**Third**, a new source of statutory revenue could be introduced; for example, an earmarked payroll tax for health. Any such proposal would be subject to close scrutiny by fiscal policy makers, however, and concerns over wage competitiveness are likely to arise. In any case, revenues from a new tax should be seen as a supplement to general revenues, given the global trend for countries to rely more and more on government budget transfers. Greater use of sin taxes (higher rates for existing taxes or the introduction of new taxes on saturated fats and sugary soft drinks) could also be considered. This is unlikely to raise significant new resources, but revenue raising should not be the primary motivation for sin taxes.

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## 4 Changes to health coverage

### 4.1 Principles and objectives

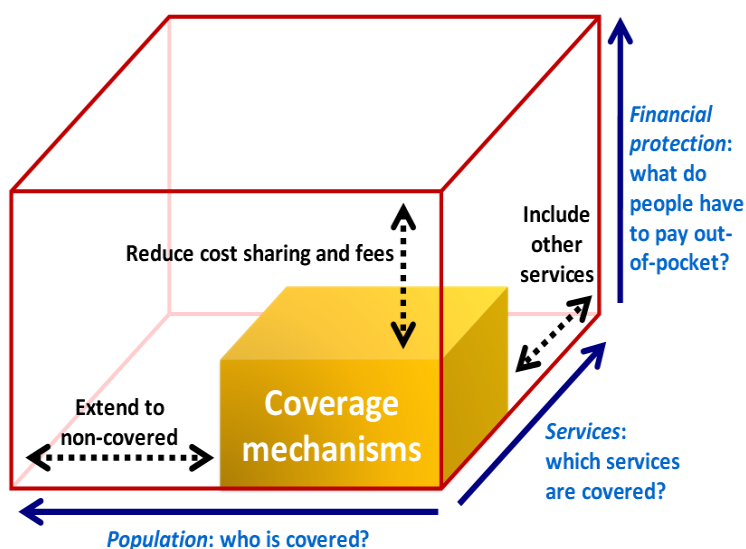
Levels of health coverage determine the extent to which people are protected from the financial consequences of ill health (financial protection) and have access to needed services. Gaps in statutory coverage create space for private finance in the form of out-of-pocket payments (including user charges) and voluntary private health insurance (PHI). How coverage is organised affects other health financing policy goals such as equity in financing, equity in the use of health care, incentives for quality and efficiency in service organisation and delivery, administrative efficiency and transparency and accountability. Crucially, we are interested in 'effective coverage', defined as the proportion of the population in need of an intervention who have received an effective intervention.

Coverage has three dimensions (Figure 4.1):

- the population covered: 'breadth' or universality
- the range of services covered: the 'scope' of the benefits package
- the share of service cost covered: 'depth', whether or not people have to pay user charges for covered services

Given the fiscal constraints governments face on one hand, and the need to meet health policy objectives on the other, key issues include the extent to which increased reliance on private finance (as a result of reductions in statutory coverage) relieves rather than exacerbates fiscal pressure; strengthens rather than undermines health system performance; and, in particular, enhances or at least does not lower efficiency in the allocation and use of statutory resources.

**Figure 4.1 Dimensions of health coverage**



Source: WHO (2010)

The second part of this chapter summarises the current level of statutory coverage in Ireland; key gaps in coverage and the role of PHI in addressing these gaps; proposals affecting health coverage set out in the 2011 Programme for Government (Government of Ireland 2011); and evidence of the consequences of coverage gaps, drawing on national data and making comparisons to other countries where possible. The chapter's third part discusses the implications of changes to coverage in Ireland in the context of international experience and evidence. A final part highlights the chapter's key points.

## 4.2 The current situation in Ireland

### Current health coverage levels

**Statutory entitlements to health care in Ireland are complex.** There are two main categories of eligibility for publicly financed health care (Table 4.1). Individuals in Category I hold a medical card giving them and their dependants more or less free access to all public health services. The remainder of the population is in Category II

and entitled to limited free maternity and infant services but required to pay in full for GP and other primary care services and to pay user charges for treatment in public hospitals.<sup>21</sup> Eligibility for a medical card is usually means tested, although some groups (e.g. foster children) have automatic entitlement<sup>22</sup> and some cards are granted on a discretionary basis<sup>23</sup> to people who have health needs that cause undue hardship. A means-tested GP visit card<sup>24</sup> was introduced in October 2005 to expand entitlement to GP services. The HSE also issues GP visit cards on a discretionary basis.<sup>25</sup>

**Table 4.1 Entitlement to publicly financed health care, Ireland, 2012<sup>a</sup>**

Type of care	Category I (medical card)	Category II	GP visit card
GP services	<ul style="list-style-type: none"> <li>▪ free</li> </ul>	<ul style="list-style-type: none"> <li>▪ pay full charge</li> </ul>	<ul style="list-style-type: none"> <li>▪ free</li> </ul>
Pharmaceuticals <sup>b</sup>	<ul style="list-style-type: none"> <li>▪ pay €0.50 per prescription item up to €10 per month per family (GMS scheme<sup>c</sup>)</li> </ul>	<ul style="list-style-type: none"> <li>▪ pay full cost up to €132 per month per family (DP scheme<sup>c</sup>)</li> <li>▪ free for specified long-term illnesses (LTI/HTD schemes<sup>c</sup>)</li> </ul>	
Public hospital inpatient care	<ul style="list-style-type: none"> <li>▪ free</li> </ul>	<ul style="list-style-type: none"> <li>▪ pay €75 per night up to €750 per year per person</li> </ul>	
Public hospital outpatient care	<ul style="list-style-type: none"> <li>▪ free</li> </ul>	<ul style="list-style-type: none"> <li>▪ free emergency department attendance with GP referral or pay €100 per visit without GP referral</li> <li>▪ free access to all other outpatient services</li> </ul>	
Other	Various entitlements to community, personal and social care services, dental, ophthalmic and aural care services; other benefits (e.g. MIC scheme <sup>c</sup> )		

Source: Authors' update of Table 1.3 in Brick et al (2010); [www.citizensinformation.ie](http://www.citizensinformation.ie)

Notes: <sup>a</sup> For comprehensive reviews of the evolution of statutory coverage in Ireland, see (Barrington 1987) and (Wren 2003); <sup>b</sup> Refers to pharmaceuticals dispensed in the community. Both Category I and Category II individuals receive free prescription drugs while in inpatient care in public hospitals.

<sup>c</sup> GMS = general medical services; LTI = long-term illness (specified conditions); HTD = high tech drugs; MIC = maternity and infant care (which entitles pregnant women to up to six free GP visits and mother and child to a free GP examination at two and six weeks after birth).

21 The charges for inpatient and outpatient public hospital care for Category II were introduced in 1987. The per-night inpatient charge was IR£10, up to an annual maximum of IR£100, while the outpatient charge was IR£10 (Government of Ireland 1987a, 1987b).

22 Retention of a medical card for a specified time period, without means testing, is also permitted in specific circumstances (e.g. participation in government employment/education schemes; retention of medical card for 3 years after return to work from period of unemployment of 12 months or more); see [www.citizensinformation.ie](http://www.citizensinformation.ie). In addition to other recommendations in relation to medical card eligibility, the 2009 Report on Public Service Numbers and Expenditure Programmes recommended that the period of retention be reduced to 1 year (McCarthy 2009).

23 In June 2012, 3.7 per cent of medical cards were issued on a discretionary basis (HSE 2012).

24 The income threshold for a GP visit medical card is 50 per cent higher than for a full medical card.

25 In June 2012, 11.8 per cent of GP visit cards were issued on a discretionary basis (HSE 2012).

Individuals in Category II, including GP visit card holders, have access to a range of public assistance schemes<sup>26</sup> including:

- the Drugs Payment (DP) Scheme<sup>27</sup>
- the Long Term Illness (LTI) Scheme for certain specified long-term illnesses (including diabetes but excluding diseases of the circulatory system, which are the leading cause of death in Ireland)<sup>28</sup>
- the High-Tech Drugs (HTD) Scheme for very expensive high-technology medicines that are usually only prescribed in hospital (e.g. chemotherapy).
- other schemes provide specific entitlements for certain groups (e.g. individuals who contracted Hepatitis C from the administration within Ireland of blood or blood products) and free immunisation and monitoring services for young children
- tax relief at the standard tax rate (20 per cent) is available for PHI premiums and for some medical expenses that are not otherwise publicly covered or covered by PHI.<sup>29</sup>
- people may also qualify for medical benefits on the basis of Pay Related Social Insurance (PRSI) contributions (under the Treatment Benefit Scheme)<sup>30</sup>

Figure 4.2 shows how the share of the population in Category I fell in the late 1990s (from around one third) due to more rapid economic growth, a steady decline in unemployment and annual increases in real incomes. However, it has increased steadily since 2005 as the economy has entered a severe and prolonged recession, and

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26 Administered by the Primary Care Reimbursement Service (PCRS), part of the HSE. Table 1.4 in Brick et al (2010) provides full details on the various schemes.

27 Launched in July 1999 (with a monthly deductible of IR£42), combining the earlier Drug Cost Subsidisation Scheme and the Refund of Drugs Scheme (GMS-PB 1999).

28 Individuals are eligible for the full cost of pharmaceuticals and appliances directly related to the schedule of illnesses covered. The full list of 15 illnesses covered is: mental handicap, hydrocephalus, cerebral palsy, muscular dystrophy, haemophilia, diabetes mellitus, diabetes insipidus, epilepsy, multiple sclerosis, parkinsonism, cystic fibrosis, phenylketonuria, acute leukaemia, mental illness (under 16 years of age) and spina bifida (PCRS 2006).

29 Routine dental treatments such as extractions, scaling and filling of teeth and provision and repairing of artificial teeth and dentures are excluded from tax relief, as are routine ophthalmic treatments (sight testing, provision and maintenance of eye glasses and contact lenses) ([www.citizensinformation.ie](http://www.citizensinformation.ie)) [accessed 12 November 2012]

30 Services covered include dental, optical and aural services (including hearing aids). For example, those qualifying are currently entitled to one free dental examination per annum.

is now at 39.0 per cent, with an additional 2.8 per cent of the population holding a GP visit card.

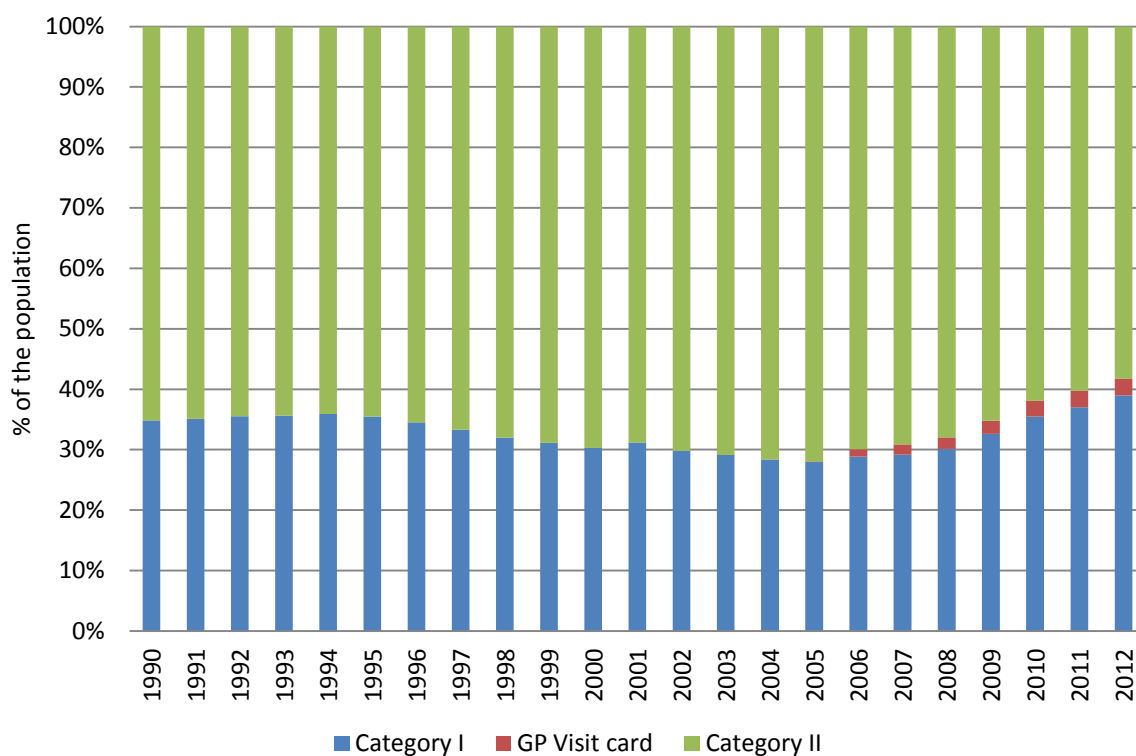
Many people in Category II and a small proportion of those in Category I purchase PHI (which plays a largely supplementary role). PHI cover has increased steadily over time, reaching a peak of 51.7 per cent of the population in 2008, but has since declined to 47.1 per cent (December 2011) (Health Insurance Authority 2012).<sup>31</sup> Originally designed to offer cover for hospital care, several PHI plans now also offer some cover for GP and other primary care expenses.<sup>32</sup> As a result, the population may be divided into four broad entitlement groups, as shown in Figure 4.3.

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31 Over the period December 2011-June 2012, the numbers covered by PHI have fallen by a further 40,000 (Health Insurance Authority 2012).

32 Government policy supports the existence of PHI and the national health strategy describes it as a 'strong complement to the publicly funded system' and a vital part of the 'overall resourcing of health care in this country' (Department of Health and Children 2001). The Government actively supports the market by subsidising the cost of private health insurance via tax relief on private health insurance premiums.

**Figure 4.2 Population coverage by category, Ireland, 1990-2012**

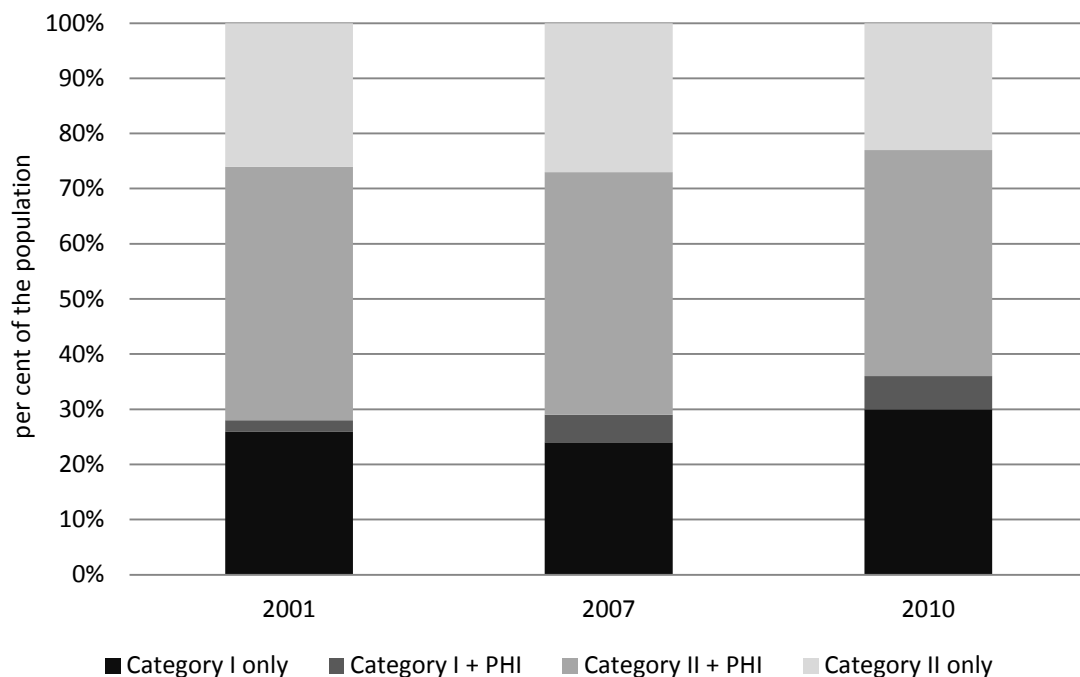


Source: CSO Databank (Table PEA01: Population Estimates (Persons in April) by Age Group, Sex and Year) [www.cso.ie/px/pxeirestat/](http://www.cso.ie/px/pxeirestat/) [accessed 12 November 2012]; HSE (2011, 2012); PCRS and GMSPB (annual reports, various years).

Note: Data refer to April of each year.



**Figure 4.3 Eligibility for publicly financed coverage and PHI coverage, Ireland, 2001, 2007 and 2010**



Source: CSO (2011a)

Note: Individuals with a medical card or GP visit card with no PHI (category I only); individuals with both a medical/GP visit card and PHI (category I and PHI); individuals without a medical/GP visit card but with PHI (category II and PHI); individuals without a medical/GP Visit card or PHI (category II only). Those with 'Category I + PHI' cover tend to be older; data from the Irish Longitudinal Study of Ageing (TILDA) have shown that while the proportion of those with 'Category I + PHI' cover is 5 per cent among those aged 50-59 years, it is 38 per cent among those aged 75-79 years and 29 per cent among those aged 80+ years (Barrett et al 2011). Based on descriptive data, these entitlement groups may be broadly ranked in terms of socio-economic status from Category I only (lowest) to Category II + PHI (highest), but overlaps in the various measures of deprivation and socio-economic status suggest that these do not describe mutually exclusive socio-economic categories (Smith and Normand 2009).

## Recent changes to coverage

**All recent changes to statutory entitlements have reduced coverage.** Most of the changes have lowered cost coverage by increasing user charges (Table 4.2). Service coverage has also been reduced through the introduction of limits to dental and ophthalmic benefits for the whole population (Table 4.2). In 2009 older people (aged 70 and over) lost automatic entitlement to a medical card. Between 2001 and 2008 they were automatically entitled to a medical card, regardless of income. Now, however, they are subject to a means test<sup>33</sup>.

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<sup>33</sup>The income threshold for a full medical card for a single individual aged under 66 years is €184 per week (less tax, PRSI and USC), with additional allowances for dependent children and for certain expenses such as childcare, rent/mortgage and travel to work. For individuals aged 70+, the income threshold for a single individual is €700 per week (gross). For both groups, income from savings/investments up to €36,000 (single individual) per annum is disregarded ([www.citizensinformation.ie](http://www.citizensinformation.ie)) [accessed 12 November 2012]

**Table 4.2 Changes to statutory entitlements, Ireland, 2008-2012**

Year	Category I	Category II (includes GP Visit card)
2008	None	<b>All:</b> increase in ED attendance charge (without a referral) to €66 (from €60); increase in the public hospital inpatient charge to €66 per day (from €60) <b>DP Scheme:</b> increase in monthly deductible to €90 (from €85)
2009	Automatic entitlement to medical cards removed from people over 70 years of age and replaced with a means test.	<b>All:</b> increase in ED attendance charge (without a referral letter) to €100 (from €66); increase in the public hospital inpatient charge to €75 per day <b>DP Scheme:</b> increase in monthly deductible to €100 <sup>34</sup> <b>Tax relief:</b> on unreimbursed medical expenses restricted to the standard rate of tax (20 per cent)
2010	<b>GMS scheme:</b> introduction of €0.50 charge per prescription item (October) <sup>35</sup> <b>Dental Treatment Services Scheme:</b> dental entitlements cut (April)	<b>DP Scheme:</b> increase in monthly deductible to €120 <b>Treatment Benefit Scheme:</b> dental and ophthalmic entitlements cut
2011	None	None
2012	None	<b>DP Scheme:</b> increase in monthly deductible to €132 <b>Treatment Benefit Scheme:</b> aural entitlements cut <b>Long-Term Illness Scheme:</b> extended entitlement to free GP care (not yet implemented and possibly delayed) <sup>36</sup>

Source: [www.citizensinformation.ie](http://www.citizensinformation.ie) [accessed 12 November 2012]

Note: Unless otherwise stated, all measures came into force on 1 January. In 2010 existing category I dental benefits (under the Dental Treatment Services Scheme) such as a biannual scale and polish, extended gum cleaning and x-rays were suspended, while the number of fillings was restricted to two per year and other services such as root canal treatment, dentures and denture repairs were restricted to 'emergency circumstances' only. An unlimited number of extractions are allowed (Irish Dental Association 2012). Category II entitlements under the Treatment Benefit Scheme (administered by the Department of Social Protection) were restricted to the medical and surgical appliances scheme, free dental examinations and free eyesight examinations. Tax relief on nursing home expenses continues to be available at the marginal rate of tax (41 per cent). In 2012 for category II the frequency of the grant for hearing aids changed from 2 to 4 years; the maximum grant available for 1 hearing aid changed from €760 to €500 and from €1,520 to €1,000 for two hearing aids.

34 The EU-IMF Memorandum of Understanding contained a requirement that the 2009 reduction in the retail mark-up on the ingredient cost of pharmaceuticals supplied under the DP Scheme (from 50 per cent to 20 per cent) should be enforced by the end of Q3 2011 (EU and IMF 2010, EU and IMF 2011). While this change also reduces the cost of pharmaceuticals to those under the threshold for the DP Scheme, it also reduces the depth of cover under the DP Scheme.

35 In June 2012, it was estimated that the charge raised €27m annually (Dáil Éireann 2012).

36 <http://www.irishtimes.com/newspaper/ireland/2012/0915/1224324049439.html> [accessed 12 November 2012]

## **Key gaps in coverage**

**Ireland is the only EU health system that does not offer universal coverage of primary care.** A recent assessment of coverage in the Irish health system found that gaps in population and cost coverage distinguished Ireland from other EU countries, particularly for GP services (Smith 2010). People without medical or GP visit cards (approximately 60 per cent of the population) must pay the full cost of almost all primary care services and outpatient prescriptions. In addition, while there is a cap on out-of-pocket spending on outpatient prescriptions (under the DP scheme) and free access to prescription drugs for people with specific long-term conditions (under the LTI scheme), there is no cap on out-of-pocket spending for other primary care services.

The assessment also noted that while rules on eligibility for coverage are set out in legislation in Ireland (as in many other countries), it is more difficult to identify the specific benefits to which individuals are entitled due to the absence of detailed benefit catalogues; in other words, the scope of service coverage is often ambiguous (Smith 2010).<sup>37</sup> This is a particular issue for community care services (e.g. home help services, podiatry, physiotherapy), where coverage varies by service and region.

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<sup>37</sup> A notable exception is the positive list of medicines reimbursable under publicly subsidised pharmaceutical schemes (Smith 2010).

## Proposed changes to coverage

Proposed changes to population coverage are part of wider government commitments to radically reform health financing in Ireland set out in the 2011 Programme for Government, which states: *‘This Government is the first in the history of the State that is committed to developing a universal, single-tier health service, which guarantees access to medical care based on need, not income’* (Government of Ireland 2011: 2). Under the banner of ‘universal health insurance’ (UHI), entitlement to GP visit cards will be extended to the whole population by 2015, giving everyone access to free GP visits. Movement towards this goal has begun with the drafting of primary legislation to provide medical cards to those covered by the LTI Scheme (Dáil Éireann 2012), although as noted, progress is slower than anticipated. The Programme for Government proposals also affect PHI: health insurers competing to provide UHI will not be allowed to sell plans that provide faster access to UHI-covered services.

It is not clear how the Programme for Government proposals will change coverage in practice, partly because details of expanded coverage of others services have yet to be specified<sup>38</sup> and partly due to the budgetary environment – for example, the proposed extension of medical cards to those covered under the LTI Scheme has been delayed.<sup>39</sup> In addition, the Programme for Government proposals do not address the complexity of the current system of entitlements: from 2015 the population may have universally free access to GP visits, but different levels of entitlement to other health services will remain.

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38 For example, in relation to mental health services, the Programme for Government states that *‘a comprehensive range of mental health services will be included as part of the standard insurance package offered under Universal Health Insurance’*.

39 The latest IMF Article IV review of the EU-IMF Programme of Support for Ireland (in July 2012) made explicit reference to concerns over spending on medical cards, but did not specify the nature of the measures required to control such expenditure  
[www.imf.org/external/np/ms/2012/071812.htm#P5\\_83](http://www.imf.org/external/np/ms/2012/071812.htm#P5_83) [accessed 12 November 2012]

## The effects of gaps in coverage

**There is evidence to suggest that gaps in health coverage in Ireland create financial barriers to access, particularly among those just above the income threshold for a medical or GP visit card (Nolan 2008a), and result in unmet need for health care. They also create conflicting incentives for providers and patients, with undesirable outcomes.** This section attempts to place Ireland in international context by drawing on international comparisons where possible. It is important to note, however, that it can be difficult to make and interpret cross-national comparisons.

### *Equity in the use of health care*<sup>40</sup>

A comprehensive analysis based on data from 2000 found that the use of inpatient hospital services in Ireland was distributed equitably across income groups (that is, based on need for health care), although a later study using a more refined measure of health need found some evidence (not statistically significant) of a pro-rich distribution in which, for a given health status, inpatient services were used more by people with higher incomes (Layte and Nolan 2004; Layte 2007).

The 2004 study found the use of GP and prescription services to be pro-poor and the use of dental and optician services to be pro-rich.<sup>41</sup> However, much of the empirical evidence has focused on adults (Layte et al 2007; Nolan 2007; Nolan 2008; Nolan and Nolan 2008; Layte et al 2009; Nolan and Smith 2012). More recent evidence demonstrates that children with ‘Category II only’ cover visit their GP significantly less frequently than those with full medical or GP visit cards (controlling for health need) (Layte and Nolan 2012).<sup>42</sup> The sharp dichotomy between the GP user charges

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40 As discussed in Brick et al (2010), there is no universally accepted definition of equity in health care, and Irish policy statements reflect this. Due to data availability, empirical assessments of equity of access to health care typically focus on patterns of health care use.

41 Ireland has also been included in a number of comparative analyses of income inequalities in healthcare use across OECD countries (van Doorslaer et al 2000).

42 There is also some emerging (albeit descriptive) evidence for the older population, i.e. those aged over 50 years of age. For those in self-related ‘good health’, 70.1 per cent of the ‘non-covered’ (over

paid by those in Category I and by those in Category II has raised concerns about the situation of people with incomes just above the eligibility threshold for a GP visit card (Department of Health and Children 2010). Research on GP visiting behaviour among people in Category II has found that the deterrent effect of GP user charges is evident not just for those at the bottom of the income distribution, but also for those at the top (Nolan 2008a).

International comparisons show that the use of doctors (especially specialists), dentists and breast and cervical cancer screening services is pro-rich in most OECD countries (Figure 4.4) (Devaux and de Looper 2012), while the use of GPs is pro-poor in a handful of countries (Austria, Belgium, Denmark and France).

#### *Affordability and unmet need*

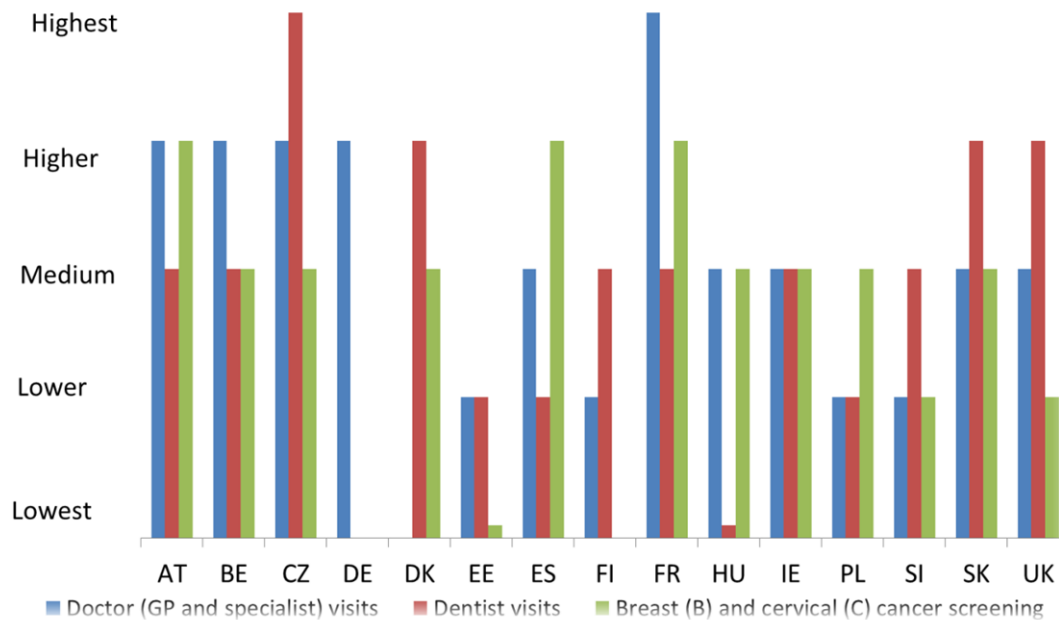
Unmet need is an alternative indicator of barriers to access. Information on unmet need is usually obtained by asking individuals if there was a time when they needed health care but did not receive it (Allin and Masseria 2009). Data from a large survey of income and living conditions (EU-SILC) suggest that, across EU countries about 7 per cent of the population reported unmet need in 2010 (on average), compared to under 5 per cent in Ireland (European Commission 2012). Between 2006 and 2010 reported unmet need increased in several countries, including Ireland. In 2010 the main reasons given for unmet need were financial (too expensive, 29 per cent), wanting to wait and see if the health problem resolved on its own (19 per cent), long waiting lists (14 per cent) and lack of time (14 per cent).<sup>43</sup>

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50) population had at least one GP visit in the previous year, in comparison with 80.9 per cent of those with PHI and 91.6 per cent of those with a medical card (Barrett et al 2011).

43 Cross-national comparisons of unmet need for health care are difficult to interpret accurately due to differences in question wording and focus across countries (e.g. medical care/GP care, reasons for unmet need), time periods and sample cover (Allin and Masseria 2009). Particular caution is needed in interpreting these data since they represent crude percentages and have not been adjusted for age or sex.

**Figure 4.4 Probability of inequity in health care use, EU OECD countries, various years**



Source: Devaux and de Looper (2012)

Notes: Only EU countries are included here. For Austria and Ireland, the findings for doctors refer to GPs only, because specialist data were missing from the original surveys. For Ireland, the Survey of Lifestyle, Attitudes and Nutrition in Ireland (SLAN 2007) did not collect data on visits to specialists.

The 2007 Irish Quarterly National Household Survey module on health care also indicates a relatively low proportion of the population reporting unmet need (around 5 per cent). However, when asking specifically about cost barriers to access, the proportion reporting unmet need tends to be higher. A cross-border study of access to GP care found that 18.9 per cent of patients in the Republic of Ireland had a medical problem in the previous year but had not consulted their GP due to cost, compared to only 1.8 per cent in Northern Ireland (where people have universally free access to health care). Over a quarter of people without medical cards in the Republic of Ireland reported being deterred from seeking GP care due to cost (O'Reilly et al 2007).

Eurobarometer survey data for 2007 indicate that only a small percentage of people in EU countries (3 per cent) report actually going without health care because it is unaffordable (Table 4.3). Across the European Union, the share of the population reporting foregone specialist and dental care is generally larger than the share



reporting foregone GP and hospital care, and 29% of unemployed people considered hospital services to be unaffordable, – a higher proportion than for any other occupational group. Table 4.3 shows that the levels reported for Ireland are much higher than the EU27 average for specialists and hospitals (higher even than the level among unemployed people across the EU27) and the fourth highest in the EU27 for GPs (after Greece, Cyprus and Portugal).

Out-of-pocket payments as a share of total spending on health in Ireland are close to the EU27 average (Table 4.3). Given that approximately 40 per cent of the Irish population are exempt from most user charges, the high levels of reported affordability problems suggest that user charges at the current level for people in Category II are a particular burden and seem to deter use. Health care affordability is likely to become an even greater issue in future, as average annual disposable income fell by 5 per cent in Ireland from 2009 to 2010 (CSO 2011b) and health care prices continue to increase, particularly dental fees and charges for private patients in public hospitals (see also chapter 2).

The nature of health coverage in Ireland produces a complex set of conflicting incentives for patients and providers, leading to outcomes that are often contrary to health policy objectives (Brick et al 2012). Some of these incentives may result in inefficient patterns of use. For example, the presence of high user charges for GP visits may encourage Category II patients to go to acute public hospitals for the management of chronic disease, rather than having their condition managed by a GP (see also Department of Health and Children 2010). This is a highly unsatisfactory pattern of use because it disrupts continuity of care, leads to worse outcomes and often results in higher costs due to complications being recognised late. More generally, there are a number of inconsistencies in the current system of entitlements that are difficult to justify, notably the selection of conditions covered by the LTI

scheme.<sup>44</sup> Ambiguity over the scope of coverage for many public health services in Ireland, particularly community care services<sup>45</sup>, often gives rise to inequities in access across different areas of the country (e.g. see Brick et al (2010) and NESF (2009) for discussion of the Home Care Support Scheme).

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44 For example, the rationale for the list of conditions covered by the LTI Scheme is unclear. The scheme does not cover diseases of the circulatory system (e.g. stroke, heart disease), even though they are the leading cause of mortality in Ireland (Brick et al 2010).

45 For example, the HSE is not legally obliged to provide podiatry services (i.e. they are not an explicit component of the benefit package for public health services), but where they are provided, the HSE gives priority to medical cardholders over 66 years, to those eligible under the Health (Amendment) Act 1996 and to individuals with arthritis, diabetes or other disabilities ([www.citizensinformation.ie](http://www.citizensinformation.ie)) [accessed 12 November 2012]

**Table 4.3 Percentage of individuals surveyed reporting health care to be unaffordable, by type of care, EU27, 2007**

Hospital		Medical or surgical specialists		Family doctors or GPs		Dentists		Out-of-pocket share of total expenditure on health (2009)	
MT	57	PT	78	EL	43	PT	82	CY	48.6
BG	52	EL	71	CY	39	EL	75	LV	38.2
HU	48	CY	66	PT	37	EE	72	EL	35.3
RO	48	BG	63	<b>IE</b>	<b>33</b>	ES	70	BG	35.3
HR	47	RO	60	TR	29	BG	65	LT	26.8
EL	45	FI	59	RO	24	SE	64	SK	25.0
PT	40	HR	56	HU	18	RO	64	HU	23.3
<b>IE</b>	<b>33</b>	MT	54	FI	17	HU	63	PL	22.4
LT	33	<b>IE</b>	<b>53</b>	HR	17	FR	62	MT	22.1
TR	32	IT	49	IT	16	CY	62	PT	20.3
BE	31	FR	48	SI	16	IT	56	EE	20.3
EE	25	HU	45	BG	16	FI	52	BE	19.6
DE	24	TR	41	BE	14	<b>EU27</b>	<b>51</b>	IT	19.4
LV	24	LT	40	SK	14	LT	51	ES	19.0
IT	23	AT	39	<b>EU27</b>	<b>11</b>	DE	48	FI	17.8
SI	23	SI	39	DE	10	SI	48	RO	17.0
FI	22	BE	38	LT	10	<b>IE</b>	<b>46</b>	TR	16.0
<b>EU27</b>	<b>21</b>	EE	37	MT	9	AT	40	<b>EU27</b>	<b>15.6</b>
PL	21	<b>EU27</b>	<b>35</b>	FR	8	DK	38	SE	15.4
NL	19	PL	31	AT	8	TR	38	CZ	14.9
FR	17	DE	28	PL	8	UK	36	<b>IE</b>	<b>14.9</b>
SK	13	LV	25	ES	7	CZ	36	AT	14.7
LU	11	SK	24	NL	6	BE	34	HR	14.5
AT	11	ES	22	EE	6	SK	34	SI	12.2
ES	10	NL	21	CZ	5	HR	33	DK	12.1
CY	10	CZ	15	LV	5	LU	28	LU	11.6
UK	8	LU	14	LU	4	NL	28	DE	11.4
CZ	8	UK	13	SE	4	PL	28	UK	10.4
SE	7	DK	7	UK	4	LV	25	FR	7.2
DK	1	SE	7	DK	1	MT	24	NL	5.7

Source: European Commission (2007), WHO (2012)

### *Effect of financial incentives on patterns of use*

PHI generates additional complexity. Despite its relatively small contribution to overall health financing in Ireland, it plays an important role in financing specific types of care, particularly public hospital care. The existence of PHI distorts the incentives facing users and providers of health care, with well-documented negative effects on equity and efficiency (Nolan and Wiley 2000; O'Reilly and Wiley 2010; Brick et al 2012).

One way of assessing inefficiency is to look at rates of hospital admission for Ambulatory Care Sensitive Conditions<sup>46</sup> (ACSCs; conditions that should be managed in primary care rather than requiring hospitalisation, also known as avoidable hospitalisations). These rates also measure primary care quality and accessibility.<sup>47</sup> A recent systematic review finds a relationship between primary care accessibility<sup>48</sup> and avoidable hospitalisations: areas with greater access to primary care tend to have lower ACSC admission rates (Rosano et al 2012). In 2009 admission rates for uncontrolled diabetes (a key ACSC) in Ireland were below the OECD average, but admission rates for COPD were the highest among OECD countries (Figure 4.5), and the total number of ACSC-related hospitalisations rose between 2005 and 2008, as did the cost of the corresponding DRGs (Sheridan et al 2012).

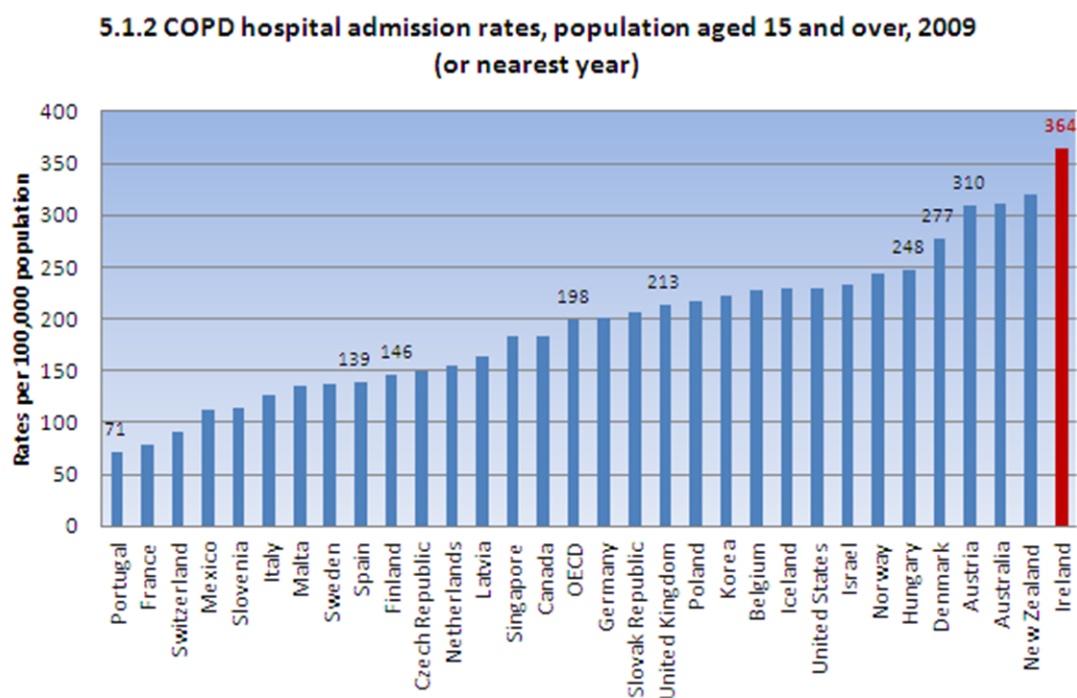
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46 The NHS Institute for Innovation and Improvement lists 19 groups of ACSCs: influenza and pneumonia, other vaccine preventable conditions, asthma, chronic heart failure, diabetes complications, COPD, angina, iron-deficiency anaemia, hypertension, nutritional deficiencies, dehydration and gastroenteritis, pyelonephritis, perforated/bleeding ulcer, cellulitis, pelvic inflammatory disease, ENT infections, dental conditions, convulsions and epilepsy, gangrene.

47 ACSC hospitalisation rates depend on factors beyond access to primary care, including prevalence of the disease and the gatekeeping role of GPs.

48 Measured by number of GPs and primary health care centres, number of GP and specialist visits and access to targeted health services.

**Figure 4.5 COPD hospital admission rates among people aged 15 years and over, OECD, 2009 (or latest available)**



Source: OECD (2011)

Note: COPD = chronic obstructive pulmonary disease

### 4.3 Policy options: international experience and evidence

This section discusses selected potential changes to health coverage in Ireland – reductions in each of the three coverage dimensions – in the context of international experience and evidence. The most common reason for wanting to reduce coverage levels in the face of fiscal constraints is to relieve fiscal pressure by reducing public spending on health care. The discussion is general and does not focus on specific Irish proposals. For each dimension, there is also discussion of the implications of promoting take up of private health insurance.

## **Changes to population coverage (breadth, universality)**

**In the last twenty years, the trend among EU countries has been to expand population coverage.** Significant changes to the basis for statutory entitlement have led to coverage expansions in Ireland (in 1991 the richest part of the population gained access to public hospital consultant services and in 2001 all older people aged 70 and over gained access to medical cards), France (2000), the Netherlands (2006), Belgium (2008), Germany (2009) and Estonia (2009) (Thomson et al 2009). The trend has been to move away from employment towards residence as the basis for entitlement and to extend public cover, particularly of primary care, to previously non-covered groups such as people who are self-employed (Belgium), long-term unemployed (Estonia) or better off or older (Ireland). By 2009, health coverage was universal or near universal in most EU countries. However, in the initial phases of the financial crisis, a handful of countries reported reductions in population coverage, including Ireland, where automatic entitlement to medical cards was removed from older people (Mladovsky et al 2012) and, more recently, other countries have followed suit (Spain and Latvia).

**Gaps in population coverage create space for 'substitutive' PHI but the role of substitutive PHI in EU countries has declined since the 1970s due to expansions in statutory coverage.** The Netherlands abolished substitutive PHI in 2006, leaving Germany as the only EU country with a significant substitutive market.

Internationally, markets for substitutive PHI are both rare and small (in terms of population coverage), with cover usually only available to selected groups determined by occupation (Austria), level of earnings and age (Germany) or (non)eligibility for statutory coverage (the Czech Republic, Estonia, Slovakia and Slovenia) (Thomson and Mossialos 2009).

**Removing entitlement from parts of the population can present an important financial risk to the government, in addition to obvious political and health risks.**

The magnitude of the financial risk depends on policy design. Excluding people from statutory coverage may exacerbate rather than relieve fiscal pressure if it is richer people who are excluded (due to risk segmentation, see next paragraph) or if their

exclusion is financially compensated by the government – for example, if they no longer have to pay contributions or if the government gives them vouchers for or (greater) tax relief on health care spending and PHI premiums.

**Tax relief that is linked to the value of PHI premiums is likely to go up if people buy more expensive plans covering a fuller range of health services than at present.** The German PHI market shows how costly more comprehensive plans can be: although it covers a relatively small share of the population (9 per cent for substitutive PHI and around 20 per cent for complementary PHI, with some overlap between these two groups) it is by far the largest in the EU in terms of premium income. In 2009 it accounted for 30 per cent of total health premium income in the EU, more than three times as much as the French PHI market (9 per cent), which covers over 90 per cent of the population (CEA 2010).<sup>49</sup>

**Risk segmentation also contributes to financial risk for the government, as seen in Germany.**<sup>50</sup> German residents earning above a certain amount (around €48,000 a year) do not contribute to the statutory health insurance scheme if they are covered by PHI. As a result, the fiscal constraint faced by the statutory scheme becomes even tighter because the scheme loses the (higher) contributions of richer (and generally healthier) people and must use its remaining contributions to cover a disproportionately high risk pool of people (Thomson and Mossialos 2006) – in other words, the amount of public revenue available per person for health care is on average lower than it would be if the whole population were covered. This situation can become acute where people have a choice of public or private cover, which gives private insurers strong incentives to select favourable risks, and where people are allowed to return to the statutory scheme at any time.

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<sup>49</sup> €33.2 billion for Germany in 2010 and €9.5 billion for France. Comparable data are not available for Ireland.

<sup>50</sup> And the experience of the Netherlands before it abolished substitutive PHI in 2006.

In Ireland there is a related problem: the higher price of privately provided care is indirectly subsidised by the government (through the Special Delivery Unit) and through subsidised PHI and tax relief. This reduces the value of PHI in terms of relieving fiscal pressure.

From a fiscal perspective, reducing population coverage seems attractive because it offers the possibility of lowering public spending on health care in absolute terms. However, the international experience – and Ireland's own experience – suggest that the extent of fiscal relief associated with this option may depend on whether policy makers are able to a) avoid financially compensating people who are excluded from public coverage and b) avoid creating incentives for undesirable behaviour by insurers, individuals and providers.

### **Changes to service coverage (scope, benefits)**

Internationally, it is probably more common for governments to try and limit or reduce the range of publicly financed benefits than to remove entitlement from groups of people. This policy option is particularly appealing, from a technical and political perspective, if coverage can be selectively and systematically withdrawn from ineffective or less cost-effective – 'low-value' – services or limited to 'high-value' services. Streamlining the benefits package in such a way has the dual advantage of enhancing allocative efficiency in public spending on health care and removing concerns about negative effects on population health. For instance, if only low-value services are excluded from publicly financed cover, then it may not matter whether people have access to these services either directly or through PHI (although it could make a difference at the individual level).

**Streamlining the benefits package based on cost and effectiveness criteria is a laudable aim but one that is technically and politically difficult to achieve**



(Robinson 1999; Jost 2005; Sorenson et al 2008). Policy makers have generally found it easier to exclude whole areas of service, such as eye care, dental care or physiotherapy,<sup>51</sup> than to systematically de-list low-value interventions. Not surprisingly, it is often the less visible services that are selected for exclusion – those that are delivered or used by people with lower political ‘voice’ than doctors. This can easily disadvantage already vulnerable populations further. It may also be that these decisions reflect judgments about the need for financial protection (where expenditure is routine) and medical necessity.

Even where systematic approaches based on health technology assessment (HTA) and other explicit priority-setting criteria are used, their effectiveness is not always evident. EU countries are increasingly trying to be more systematic in making decisions about the range of services that should be publicly financed – with Germany and France now treading ground broken by the United Kingdom, the Netherlands, Sweden and the US state of Oregon in the 1990s. While these efforts can be beneficial, and should not be discouraged, their benefits are mainly felt at the margin. Due to resource, technical and political constraints, assessment is mainly applied to new technologies, economic evaluation is not used in a way that captures important opportunity costs and politically unpopular decisions may be overturned (Sorenson et al 2008; Ettelt et al 2010). Efforts to streamline coverage scope may not result in substantial net savings to the public budget for health. Nevertheless, the fiscal constraint Ireland faces presents an opportunity to enhance efficiency in public spending by excluding coverage of services (or preventing patterns of use) that are already known to be of low value.

**Relying on PHI to cover excluded services presents several risks.** Policy makers may exclude some higher value services in the expectation that people will access them through ‘complementary’ PHI. There are two main risks here. First, private

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51 This is not always an easy option. Governments have tried to exclude these services and then re-introduced them following adverse media coverage – for example, dental care in Germany in the 1990s and spectacles in France in 2008.

insurers may not develop the relevant products if they fear plans will not be sufficiently profitable due to adverse selection, lack of consumer interest or the small size of the population. In practice, markets for PHI covering excluded services are not widespread and rarely cover a large proportion of the population (Thomson and Mossialos 2009). Second, if a PHI market does develop, it may undermine equity of access to health care, as seen in Canada, where around two-thirds of the population have PHI covering outpatient prescription drugs (Hurley and Guindon 2013).

It is pertinent to consider a further serious risk in light of the Programme for Government proposals to introduce competitive statutory health insurance in Ireland. The experience of the Netherlands and Switzerland is that allowing the same insurers to offer both publicly financed and private health insurance in a competitive environment – even when so-called tied sales are illegal – presents a major obstacle to consumer mobility, particularly among higher risk people, and therefore undermines a central pre-condition for genuine competition between insurers (Paolucci et al 2007; Roos and Schut 2011).

### **Cost coverage (depth, user charges)**

**Economic arguments in favour of user charges do not hold in health care.** User charges are generally imposed to raise revenue for the health system or to control third-party payer costs. Economic theory suggests user charges will make people more discerning in their use of health care – that is, faced with having to pay at the point of use, people will selectively forego low-value services – which will in turn make health care spending more efficient. However, it is based on assumptions about information and consumer behaviour that do not hold when it comes to health care.

**Strong evidence indicates that user charges do not have a selective effect;** rather, they reduce the use of low- and high-value health care in almost equal measure – a research finding that holds across all types of health care, including prescription drugs (Newhouse and The Insurance Experiment Group 1993; Swartz 2010). Thus, applying user charges ‘across the board’, as opposed to selectively applying them to low-value

care only (discussed below) would be likely to deter the use of necessary treatment (even where charges are quite low) and might therefore have a negative impact on health. International evidence suggests that public insurance status and user charges affect health outcomes as well as health care use (Newhouse and Insurance Experiment Group 1993; Currie and Gruber 1996; Chernew and Newhouse 2008; Currie et al 2008; Lin 2009).<sup>52</sup>

**Although it is challenging to demonstrate empirically, there is no evidence to suggest that user charges lead to long-term cost control** (Swartz 2010). Nor is there evidence to suggest user charges are effective in containing public spending on health care. Reviews of user charges for prescription drugs conclude that not only do they not achieve net savings for payers, in some cases they are associated with increased expenditure due to the negative health effects of people foregoing needed care or the higher cost of people accessing free but more expensive forms of care (for example, using emergency services rather than seeing a GP) (Lexchin and Grootendorst 2004; Gemmill et al 2008). The high transaction costs associated with collecting and enforcing user charges can also limit their potential to contain public spending on health. Indeed, some EU countries have abolished charges due to the absence of net savings after accounting for administrative costs (Thomson and Reed 2012).

**A value-based approach to user charges policy can play a role but is not useful in all situations and should be accompanied by supply-side measures.** Such an approach would entail aligning incentives to encourage people to use high-value care and discourage them from using low-value care (Fendrick and Chernew 2006; Chernew et al 2007). It would also recognise that value in health care may be determined by individual characteristics. An example of this approach is to charge people if they use less cost-effective drugs when more cost-effective alternatives are available. The value-based approach is most likely to be useful where there is clear

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<sup>52</sup> For example, it has been shown that expansions in public health insurance (i.e. Medicaid) cover in early childhood in the United States lead to better future health (Currie et al 2008).

evidence of value (but this is not the case with many health care interventions); where patient preferences are important; or where incentives may be more effective than rules in changing behaviour (or simply more politically expedient). Consequently, it is very far from a panacea. Nor is it likely to contribute to lower expenditure, not least because of the potentially high transaction costs involved. Finally, to avoid penalising patients financially for inappropriate treatment decisions made by providers, it is essential for value-based user charges to be accompanied by measures to ensure that health care is prescribed and provided in the most appropriate way possible. In many cases, targeting both rules and incentives at providers (as opposed to patients) is likely to be much more effective.

**Where user charges are implemented, and given their many drawbacks, the accompanying policy should aim to protect poorer people and people with chronic conditions.** Faced with political pressure to reduce government expenditure, policy makers may allow themselves to be persuaded that they have no alternative but to charge users. If this happens, research evidence underlines the importance of putting in place adequate protection mechanisms so that the financial burden weighs least heavily on people with low incomes and people who regularly use health care. While all EU countries charge patients for some health services (most commonly, outpatient prescription drugs), many exempt specific types of care and specific groups of people. Emergency care, maternity care, primary care and inpatient care are the four types of care EU countries are least likely to charge patients for. Children and low-income people are the two groups most likely to be exempt. To secure some degree of financial protection, it is also advisable to cap the amount of money patients are required to pay for a given service or a given period of time.

**Ireland is already an extreme outlier among EU countries when it comes to user charges policy.** In addition to being the only country not to offer universal coverage of primary care, its primary care prices are relatively high (around €51 per GP visit in

Ireland<sup>53</sup> compared to around €22 in France), compounding the financial burden on patients. It is one of only three countries to charge non-poor households for essential prescription drugs (the other two are Cyprus and Malta). It is also one of only six countries to charge people for non-referred visits to hospital emergency departments – and again, the charge imposed is much higher than in other countries (€100 compared to between €2 and €30 in other countries). Finally, its caps on out-of-pocket spending through user charges are set very high (Table 4.6).

Some countries use complementary PHI as a protection mechanism. Complementary PHI cover for statutory user charges is the dominant role VHI plays in France, Latvia, Luxembourg and Slovenia. To stimulate demand for this type of PHI product, user charges need to be very high and applied across the board, often in the form of co-insurance<sup>54</sup>. Insurers must be willing to supply the appropriate cover and they may be more likely to do so if demand is high across a broad spectrum of the population, so as to avoid adverse selection problems.<sup>55</sup> Covering a large share of the population also spreads risk, enabling lower premiums.

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53 [http://corporate.nca.ie/eng/Research\\_Zone/price-surveys/March\\_2010\\_doctors\\_and\\_dentists\\_prices\\_survey.html](http://corporate.nca.ie/eng/Research_Zone/price-surveys/March_2010_doctors_and_dentists_prices_survey.html) [accessed 12 November 2012]

54 Co-insurance is a form of user charge in which the user pays a set percentage of the service price.

55 That is, to avoid a situation in which only those who knew they were going to be using health care on a regular basis would purchase VHI.

**Table 4.6 Caps on out-of-pocket spending through user charges, selected western European countries, 2012**

	Primary care annual cap	Outpatient prescription annual cap	Inpatient annual cap (daily charge)
Austria	€10 (poor: free care)	2 per cent of income	28 days (10 per cent)
Belgium	€450-1,800 depending on income		
Denmark	Free care	€480 (chronic only)	Free care
Finland	€630 (minors: free care)	NO CAP	7 days (minors only) (€32)
France	NO CAP (chronic free, minors free primary care)		31 days (€18 + 20 per cent)
Germany	2 per cent of income (1 per cent for chronically ill)		
Ireland	NO CAP (poor: free care)	Free (LTI Scheme); €120 (low income, i.e. medical card); €1,584 (DP Scheme)	€750 (poor: free care) (€75)
Netherlands	Free care	€220	
Norway	€250		
Sweden	€105	€205	NO CAP (€10)
Switzerland	€580		
UK	Free care	Northern Ireland, Scotland, Wales: free care England: €130	Free care

Source: Thomson and Reed (2012)

However, in France and Slovenia the existence of PHI covering user charges has severely exacerbated inequity in the use of health services, while in France it has undermined the effectiveness of recent efforts to make user charges more value-based. These two countries have adopted very different approaches to securing access to PHI. France relies on cultural norms to ensure insurers offer open enrolment and community rating, as well as providing substantial tax subsidies so that poorer people can afford to buy PHI, but PHI coverage is still not universal, inequity persists and policy makers are coming to question the costs involved (Couffinhal and Franc 2013). Slovenia has introduced a stringent regulatory framework requiring insurers to offer open enrolment with community rating and a risk equalisation scheme. In 2010 the European Commission challenged the risk equalisation scheme on state aid grounds and it is currently pursuing infringement proceedings against the Slovenian Government (European Commission 2011).

#### 4.4 Summary

This chapter has reviewed health coverage in Ireland and the effects of gaps in population, service and cost coverage. Ireland is unique among EU countries in not providing universal coverage of primary care. Its system of entitlement to publicly financed health care is also complex. Research shows that gaps in coverage in Ireland already create significant financial barriers to access, particularly for people who do not have medical cards or PHI, resulting not only in unmet need but also in inequitable and inefficient patterns of use. International comparison suggests these barriers are often substantial relative to most other EU countries, especially for primary care.

Recognising these shortcomings, the Programme for Government proposals aim to expand coverage of primary care and remove some of the perverse incentives that lead to inefficient patterns of use. However, they will not address the complexity of entitlements or fully resolve the issue of financial barriers to essential health services. Implementation of the Programme for Government proposals is also challenged by the scale and speed of the required reductions in public spending on health.

Severe financial pressure may force policy makers to consider ways of reducing coverage. The **first** option, to reduce population coverage by lowering or removing the entitlements of richer people, would be unlikely to provide fiscal relief given the current design of government subsidies for privately provided care and PHI. It might also be politically challenging to implement.

The **second** option is to streamline the scope of publicly financed benefits in a systematic way based on evidence of effectiveness and cost-effectiveness. This would enhance efficiency in the use of statutory resources, but might not result in substantial net savings to the public budget in the short term to medium term, as additional investment in health technology assessment would be necessary. Nevertheless, a good starting point would be to exclude from statutory coverage services and patterns of use and delivery that are already known to be of low value. Changes in service coverage should also be informed by demographic changes and changes in the burden

of disease, and complemented by on-going efforts to develop best practice guidelines and care pathways in the National Clinical Programmes (see chapter 5).

A **third** option is to raise user charges or adapt the design of user charges policy. Higher user charges for primary care would conflict with the stated direction of policy in Ireland and further damage access to needed services. GP visit charges are already high for people without medical cards, and since these people pay the full cost of GP visits in any case, there is actually little room for manoeuvre. Higher user charges for primary care would also undermine efforts to enhance efficiency by shifting use away from hospitals and towards community-based settings. An alternative might be to place a greater share of the financial burden on those who are covered by PHI – for example, by increasing charges for private treatment in public hospitals. This might not result in savings if PHI premiums increase, forcing government subsidies for PHI to rise, but there might be some offsetting if the number of people covered by PHI declined at the same time.

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## 5 Improving health services efficiency

### 5.1 Principles and objectives

Measures that target the supply side of health care offer considerable scope to improve health system functioning in comparison to those focused on curbing use by patients. Changes in how health care is purchased, in how providers are paid and in how care is delivered offer significant potential to enhance efficiency, quality, equity, transparency and accountability.

Many countries have moved away from passive reimbursement of providers towards strategic purchasing, explicitly linking resource allocation to information about health needs, clinical effectiveness, cost-effectiveness and provider performance (Figueras et al 2005). Encouraging strategic purchasing involves thinking about:

- **what to purchase:** the range of benefits to be covered (see chapter 4); health needs assessment; how to set priorities; the use of health technology assessment to determine effectiveness, cost-effectiveness and best practice; dissemination of guidelines; investment in prevention
- **who should purchase:** single or multiple; territorial; competition
- **from whom:** the range of individuals and organisations eligible to provide (publicly financed) services; the mix of skills required
- **at what price:** how best to pay providers; pricing and reimbursement of drugs and devices
- **under what conditions:** linking payment to performance; value-based pricing for drugs and devices; selective contracting; competition; provider autonomy

Key principles underpinning strategic purchasing include:

- **matching resources to need:** risk-adjusted resource allocation to purchasers and providers; capacity planning for human resources, infrastructure and expensive medical equipment

- **reducing waste:** delivering care at least cost by changing the skill mix, encouraging day surgery and shifting care to community settings (where this is more efficient); strengthening primary care to avoid unnecessary hospitalisation; avoiding fragmentation; avoiding duplication; minimising administrative costs
- **ensuring quality:** addressing unwarranted variations in care delivery; establishing patient pathways; improving care co-ordination; putting in place good information systems
- **setting priorities:** delivering cost-effective services; balancing cost-effectiveness with equity principles

Some of these principles are clearly reflected in commitments noted in the Programme for Government (Government of Ireland 2011). Nevertheless, they need to be fleshed out and implemented in a coordinated way. This chapter focuses mainly on GP payment, hospital payment and the pricing and reimbursement of pharmaceuticals, since these have been identified as priority areas. The Programme for Government commitments include plans to introduce mandatory purchase of health insurance with choice of insurer for all residents – a form of competition between insurers. The issue is discussed very briefly in section 5.3, but detailed analysis is beyond the scope of this ‘rapid response’.

## **5.2 The current situation in Ireland**

Current purchasing arrangements for public health services in Ireland are largely co-ordinated by the Health Service Executive (HSE), which often fulfils a dual purchaser and provider role (e.g. it both owns and operates a number of public hospitals). Payments to service providers comprise payments to: direct employees of the HSE (e.g. medical consultants, nurses, physiotherapists, administrative staff etc); independent contractors such as GPs, pharmacists and dentists (who enter into contract with the PCRS (Primary Care Reimbursement Service)); and institutional providers (e.g. acute public hospitals, voluntary organisations providing community care services). The PCRS co-ordinates the purchase of services (e.g. GP care) and



goods (e.g. pharmaceuticals) for individuals who are eligible for free or subsidised public health services under the various State schemes.

### **Paying for and delivering primary care**

A review of resource allocation mechanisms in the Irish health service in 2010 noted the predominance of the historical budget method of allocating resources to service providers in the primary and community care area, with only a very limited role for ‘strategic purchasing’ methods (Brick et al 2010).<sup>56</sup> Current **payment arrangements for primary care providers** contracted by the PCRS are described in detail elsewhere (Brick et al 2010). As part of the Financial Emergency Measures in the Public Interest (FEMPI) Act 2009, there were reductions in the rates of payment to GPs in 2009, 2010 and 2011 (Government of Ireland 2009; Government of Ireland 2010; Government of Ireland 2011). The 2011 Programme for Government contains a commitment to introduce a new contract for GPs, to pay GPs mainly by capitation and to reduce the amount GPs are paid (Government of Ireland 2011), while the EU-IMF Agreement contains a requirement to ‘*remove restrictions on GPs wishing to treat public patients*’ (EU and IMF 2010: 24).<sup>57</sup> GPs have noted publicly their objections to the various FEMPI cuts (Cahill 2012), but service provision has not been affected.

**Reform of delivery structures** (e.g. reducing reliance on costly secondary care services, reconfiguring staff mix etc) is considered an important component of the drive for increased efficiency. The Programme for Government notes that the integration of care in all settings is key to efficient health care delivery, and contains a commitment to establish ‘*an Integrated Care Agency which will oversee the flow of centrally tax-funded resources between the different arms of the system so that there*

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<sup>56</sup> See also CAG (2010, 2011).

<sup>57</sup> The latter reflects, but does not go as far as, an earlier recommendation by the Special Group on Public Service Numbers and Expenditure Programmes to introduce a tendering system for the provision of GP (and pharmacy) services under the various State schemes (McCarthy 2009). These restrictions were removed under the Health (Provision of General Practitioner Services) Act 2012, which was enacted in March 2012 (Government of Ireland 2012).

*are incentives for care to occur in the best setting'* (Government of Ireland 2011: 6). Previous analyses of the Irish health system noted the barriers to the delivery of integrated care, such as incompatible financial incentives (on the part of both users and providers), human resource constraints and poorly-developed community care services (Department of Health and Children 2010; Brick et al 2012). The Public Service Agreement is being used to secure enhanced flexibility in working arrangements across the public health service.

A key component of integrated care is the **primary care team** (PCT) an inter-disciplinary approach to primary care provision involving not only GPs and nurses/midwives, but a wide range of other personnel including various types of therapists, social workers, home helps etc<sup>58</sup>. Despite the targets set out in the 2012 HSE National Service Plan, progress on the development of PCTs to date has been slow (CAG 2011; Department of Health 2011; HSE 2012; HSE 2012). Barriers to the further development of PCTs include IT constraints, the absence of a health and social care network structure (to co-ordinate access to specialist and diagnostic services), poorly functioning change management processes, difficulties with the re-assignment of staff and difficulties in sourcing accommodation for PCTs (CAG 2011; Department of Health 2011). Earlier concerns over the future shortage of GPs (Layte et al 2007; Competition Authority 2009) have been helped by the expansion in GP training places (HSE 2010), although recent papers have suggested that various strategies such as improving the efficiency of GPs and using practice nurses and pharmacists to conduct some primary care services, rather than recruitment of additional GPs, offered the best solutions to the projected future shortfall in GPs (Teljeur et al 2010).

As a first step to secure greater efficiencies in the provision of **pharmacy services**, recent attempts have focused largely on securing price reductions, rather than attempting to influence product mix or volume. Setting the reimbursement price for

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<sup>58</sup> The development of PCTs as a policy aim was first articulated in the 2001 Primary Care Strategy (Department of Health and Children 2001) and most recently re-affirmed in the Programme for Government.

pharmacy services in Ireland follows a complex procedure (Brick and Nolan 2010; Brick et al 2010; Gorecki et al 2012). In recent years, the ex-factory price, wholesale mark-up and retail mark-up have all been targeted (see Table 2.3 in Gorecki et al (2012) for a summary). However, in spite of these reductions and draft legislation on reference pricing and medicine interchangeability (Government of Ireland 2012), there have been few attempts to adopt initiatives such as competitive tendering for high volume off-patent products.

Existing agreements with pharmaceutical manufacturers (which set the ex-factory price of pharmaceuticals on the Irish market) have been re-negotiated and a new agreement was reached on 15 October 2012. The new deal, with an expected value of €400 million over three years, includes reductions in the cost of in-patent and off-patent drugs, as well as securing the provision of new and innovative drugs. At the time of writing, discussions with representatives of the generic drugs industry were in progress and a National Task Force on Prescribing and Dispensing had been established (Department of Health 2012). The EU-IMF Agreement contains a requirement for the reduction in the 50 per cent retail mark-up to 20 per cent to be enforced. This has been interpreted as referring to the community drugs schemes and no further action is required(see chapter 4) (EU and IMF 2010).

### **Paying for and delivering acute hospital services**

As described in detail in (Brick et al 2010), all public hospitals receive annual budgetary allocations in return for undertaking activity levels specified in the HSE's annual National Service Plans. Budgets are mainly determined on the basis of historic factors. A majority of hospitals also participate in the National Case-mix Programme, which allocates a small proportion of resources (retrospectively) on the basis of efficient service delivery; between 2004 and 2010, case-mix-adjusted payments have accounted for about  $\pm 3$  per cent of hospitals' total costs) (Brick et al 2010). The Programme for Government contains a commitment to pay hospitals according to the care they deliver and to incentivise them to deliver more care in a 'money follows the patient' system (Government of Ireland 2011), although precise details on what this

entails have yet to be provided. The payment of public hospital consultants has been the subject of much discussion since the agreement of a new consultant contract in 2008, with the degree of compliance by some consultants in relation to private practice also coming under particular scrutiny (CAG 2010). The Programme for Government states that *'under a new consultant's contract hospital consultants' remuneration will be reduced'* (Government of Ireland 2011: 6).

In 2008 34 of the 52 acute public hospitals operating in Ireland were owned and operated by the HSE (Brick et al 2010). The remainder, termed 'public voluntary hospitals', are owned and operated by voluntary organisations such as religious orders. They provide services as specified in service-level agreements with the HSE. While public voluntary hospitals are publicly funded but privately owned, HSE hospital managers are directly accountable to the HSE (Brick et al 2010). There are also differences in financing arrangements, as HSE hospitals must return any underspend to the HSE, while voluntary hospitals are allowed to retain any savings. Potentially more important in the current economic climate is the treatment of income within hospital budgets; HSE hospitals are funded on a gross basis (which reduces the incentive to engage in income collection), while public voluntary hospitals are funded on a net basis. As of June 2012, acute public hospital services were nearly €180m in deficit for the year to date (i.e. approximately 8.5 per cent over budget) (HSE 2012). The Programme for Government contains a commitment to establish all acute public hospitals as independent, not-for-profit trusts (Government of Ireland 2012).

As pay accounts for approximately 50 per cent of overall public health expenditure (but can be as high as 70 per cent in the acute hospital sector) (Brick and Nolan 2010), securing greater efficiencies in this expenditure via reductions in numbers, as well as optimal use of existing staff, has become a key concern. In common with the general public service, the public health service is subject to a moratorium on recruitment and promotions. The 2012 Employment Control Framework whole-time equivalent target for the public health service is approximately 102,100 (and employment stood at 102,192 in June 2012) (HSE 2012). However, in this context, there are concerns over the costs of employing replacement agency staff, and the impact of the EU Working Time Directive for NCHDs (non-consultant hospital doctors). Apart from restrictions

on numbers employed, changes to staffing levels, skill mix and staff attendance patterns/rosters are being implemented within the context of the 2010-2014 Public Service Agreement. The second progress report of the Implementation Body noted the significant savings that had been achieved in the health sector via the introduction of a single procurement model, the redeployment of 4,500 staff over the period April 2011 to March 2012 (e.g. over 1,000 staff redeployed from the HSE to the Department of Social Protection with transfer of Community Welfare Services) and changes to rosters (Implementation Body 2012). However, the prohibition on pay cuts as set out in the Public Service Agreement has generated increasing debate over the extent to which further savings can be realised. An envisaged agreement between the HSE and the Irish Hospital Consultants Association (IHCA) on new work practices is expected to result in savings of €200m for the health service<sup>59</sup>. However, the agreement has been referred to the Labour Court.<sup>60</sup> Meanwhile, a lower pay scale for future recruits of between €116,000 and €121,000 per year has been introduced from 1 October 2012.

Another recent focus of the Government and the HSE has been on initiatives to increase efficiency by improving delivery, including work done by the Special Delivery Unit).<sup>61</sup> Substantial and longer term changes in the delivery of care will result from the shift to new models of care for (particularly chronic) diseases under the National Clinical Programmes (HSE 2012). These programmes aim to define improved and more efficient patient pathways, and to encourage a shift from reactive to planned patient care. The programmes have been designed to achieve high levels of acceptance from clinicians, who have been closely involved in their development. In

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<sup>59</sup> <http://www.dohc.ie/press/releases/2012/20120917.html> [accessed 12 November 2012]

<sup>60</sup> As of end October 2012, the IHCA are refusing to attend the Labour Court (see <http://www.irishtimes.com/newspaper/breaking/2012/1023/breaking10.html>) [[accessed 12 November 2012]

<sup>61</sup> Wider public service reforms in relation to shared services and external service delivery as set out in the Programme for Government and the Public Service Reform Plan are also relevant to the health service (see <http://per.gov.ie/2012/07/25/public-service-reform-the-balance-sheet-a-paper-by-robert-watt-secretary-general/>) [accessed 12 November 2012]

many cases the ambition is both to improve the quality of patient care and to release resources for reinvestment in the service.

The approach has similarities to the successful development of new models of cancer care in Ireland, which has achieved important improvements in outcomes and has reduced variation in the care provided. An important difference is that the Cancer Control Programme (National Cancer Forum 2006) was developed in the context of increases in statutory resources for health.

It is likely that the introduction of new care models will improve efficiency and outcomes and experiences for patients. However, the time scale for any substantial improvement is likely to be three to five years, given the need to put in place new pathways, information systems, skills and facilities.

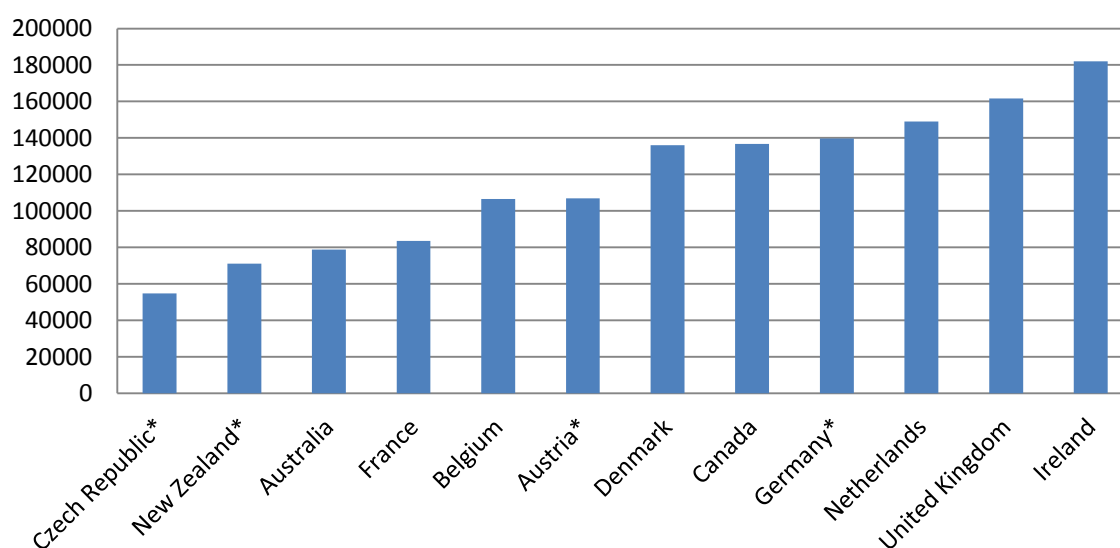
### **5.3 Policy options: international experience and evidence**

#### **Paying GPs**

GPs are the first point of contact with the health system for most people and play an important role in referring patients to other health services. The way in which GPs are paid and deliver services is therefore crucial for ensuring efficient, high-quality primary care. International data suggest that GPs in Ireland have on average a higher income than GPs in any other OECD country (Organisation for Economic Co-operation and Development) (OECD 2012). In the subset of countries in which GPs are self-employed (as opposed to salaried), Ireland is also the highest payer (Figure 5.1). Furthermore, Irish GPs have the second highest (next to the United Kingdom) remuneration relative to the average national wage (3.37 in 2008), compared to self-employed GPs in other OECD countries (data not shown in Figure 5.1) (OECD 2012). However, caution is needed in interpreting the Irish data. On one hand the data exclude practice expenses and reflect levels before the 2009-2011 FEMPI cuts, resulting in a possible over-estimation in international comparisons (OECD 2012); on the other hand, the Irish figures include only that portion of income that is derived

from the GMS (medical card) contract and not additional income from private patients (who constitute over 60 per cent of the Irish population), resulting in a possible underestimate (Brick et al 2010). Furthermore, the data do not take into account the differing roles GPs may have across countries. **Therefore, while the OECD figures suggest there is considerable scope for a reduction in GP income in Ireland, there is a need for improved data to conduct a proper comparative assessment.**

**Figure 5.1 Incomes of self-employed GPs, selected OECD countries, US\$ PPP, 2009**



Source: OECD (2012)

Notes: Data from 2007 for countries marked with \*; all data refer to the latest year available.

International evidence suggests GP payment in Ireland could be improved in three ways. First, the move towards capitation with risk adjustment is generally seen as a mechanism for increasing efficiency by reducing the incentives for supplier induced demand associated with fee-for-service (FFS) (Robinson 2001; van Ginneken 2013). In most EU countries statutory purchasers pay GPs through a mixture of capitation and (capped) FFS (van Ginneken 2013). However, the proportion of GP payment from capitation is relatively low in Ireland (49.6% of total income under the GMS

contract<sup>62</sup>(Brick et al 2010) compared to 100% in Spain, 80-90% in Sweden, 70% in the Czech Republic, 65% in the UK (with an additional 25% as P4P), and 60% in the Netherlands) (van Ginneken 2013). **Increasing the proportion of GP income from capitation could enhance efficiency (and access, see chapter 4) by placing the provider at greater financial risk.**

Second, while Ireland relies on age and gender as risk adjusters, payers in other countries have moved towards more sophisticated risk adjustment formulas which include deprivation, pharmaceutical consumption and quality (van Ginneken 2013).<sup>63</sup> **More sophisticated risk adjustment may enhance efficiency, quality and equity,** although there is little evidence relating specifically to capitation payment in primary care. Third, the current remuneration system does not provide incentives for increasing quality of care. The additional FFS elements of the GMS contract have remained unchanged for many years (although the levels of payment have been reduced via FEMPI), and focus on processes of care rather than outcomes (e.g. suturing, vaccinations). Emerging evidence suggests that pay for performance (P4P) has had some positive impacts on quality and governance in primary care, at least in the short term, although there is scope for unintended consequences and transaction costs may be high (Cromwell 2011; Maynard 2012). Thus, while **linking payment to performance should be considered, it may be part of a short-term approach and policy makers should pay careful attention to design issues** (Nolan 2011).

Other payment innovations that blend elements of various payment mechanisms such as capitation with fee-for-service carve-outs, budgets with individual fee-for-service or ‘contact’ capitation, case rates for defined episodes of illness and capped or decreasing reimbursement rates may also help promote health system goals (Robinson

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<sup>62</sup> Any reforms to the current capitation system would affect only that portion of GP income that is derived from GMS patients.

<sup>63</sup> In 2010 the Government simplified the risk adjustment process by removing the distance-related component (prior to 2010, there were 5 categories of payment for each sex/age group based on distance from the doctor’s surgery, i.e. <=3 miles, 3-5 miles, 5-7 miles, 7-10 miles and 10+ miles (Government of Ireland 2009).



2001; van Ginneken 2013). In any provider payment reform, factors likely to influence successful implementation include the way provision is organised, regulation and interaction with incentives. As a minimum, policy makers should try to ensure that incentives are aligned across different care sectors and across providers and users.

### **Paying for hospital services**

As in many other European countries, indicators such as day patient ratios, day case procedures, length of stay and bed-day suggest increases in efficiency in Ireland's hospital sector in recent years, although in some cases below targets set by the Health Service Executive (Thomas et al 2012). The variation across hospitals also suggests more could be done by some providers. However, these measures may not reduce costs and could even increase overall volume and costs if not managed carefully. Overall, a reduction in hospital costs in Ireland in the short term is challenging, given the Public Service Agreement (which precludes the reduction of physician pay rates) and the existence of significant waiting lists for outpatient and inpatient hospital services, which means any reduction of beds would require considerable reconfiguration (see the discussion in chapter 2 on waiting times and the undersupply of nursing home beds and below on coordinating hospital, primary and community care) (4). These issues need to be considered in any reforms aiming to reduce hospital costs.

In line with almost every other EU health system, Ireland has been moving towards using DRGs (Diagnosis-Related Groups, known as case-mix based payment in Ireland) to pay hospitals. DRGs can enhance efficiency and reduce costs if carefully designed (Busse and Quentin 2011), although the desired effects may be apparent in the medium term rather than in the short term. However, the incentives for increased efficiency in the Irish DRG system are potentially weaker than in other countries, for the following reasons.

- Perhaps as important as any limitations in the design of the DRG system is the very small proportion of hospital costs (around 3% in Ireland, compared to about 80% in France and Germany and 60% in England) covered by DRGs; this severely limits the potential for this payment mechanism to improve performance (Cots et al 2011) and suggests that **stepped up implementation of the DRG system is necessary**.
- **The potential to use the DRG system for strategic purchasing has not been realised in Ireland.** In countries such as Hungary (Gaál et al 2011), DRG weights are in some cases set higher or lower than the actual average cost of services in the relevant DRG group in order to motivate providers to increase or decrease the volume of a particular case or to shift to alternative treatment modalities. Indeed, DRG prices in Hungary have been used to cut drastically or completely abolish some services and to incentivise shifting to outpatient care or day cases. Much could be learnt in Ireland from this approach.
- Ireland does not include capital costs in DRG weights, in contrast to several other EU countries. **Including capital costs can create incentives for the reorganisation of care** if the legal and institutional context facilitates the (intended) reconfiguration of services through the hospital payment system (Busse and Quentin 2011). However, countries such as Hungary have managed to promote reconfiguration through the DRG system even without including capital costs in the weights (Gaál et al 2011).
- Since shifting secondary care to the primary care sector is currently a priority in Ireland (see below), **the lack of incentives for reconfiguration in the DRG payment system seems to be out of line with stated policy goals**.
- As in many other countries, there are inadequate and fragmented health information systems in Ireland, resulting in **insufficient data to adjust payments for readmission across hospitals and integrate other quality controls into the DRG system**, potentially resulting in inefficient service delivery.

- Ireland’s DRG rates are relatively high. Although comparative price data need to be interpreted with caution, a comparison of Irish and German hospital DRG rates (Table 5.1) shows the tariff in Ireland is much higher and has increased more rapidly (until 2012). This suggests there may be **scope for price reductions in the DRG system**. The high level of Irish DRG rates may in part reflect high staff salaries, thus the scope for DRG price reductions is currently limited by the Public Service Agreement. Consequently, reducing DRG prices without addressing underlying expenditure patterns through reconfiguration and pay adjustments risks undermining the “money follows the patient” system.
- **The lack of hospital autonomy in the public sector is a significant obstacle to realising the potential of the DRG system** (see below).

**Table 5.1 DRG base rate price per case, Ireland and Germany, 2007- 2012**

Year of budget	Year to which cost and activity data relate	German federal base rate (€)	Base rate North Rhine Westphalia (€)	Annual % increase North Rhine Westphalia	Irish national average inpatient base price (€)	Annual % increase Ireland
2007	2005		2,736		4,403	
2008	2006		2,754	0.66%	4,677	6.22%
2009	2007		2,848	3.41%	5,030	7.55%
2010	2008	2,936	2,895	1.65%	5,219	3.76%
2011	2009	2,964	2,913	0.62%	5,217	-0.04%
2012	2010	2,992	2,961	1.65%	4,773	-8.51%

Source: EuroDRG project 2012

Note: Ireland and Germany both use a variant of the Australian DRG system with the same definition of a relative weight (1.0 = average of all patients in the country)

**In sum, international evidence suggests that further, careful development of the DRG payment system to create appropriate incentives can promote more efficient resource use and reconfiguration, which could lower expenditure in the hospital sector.**

## **Provider autonomy**

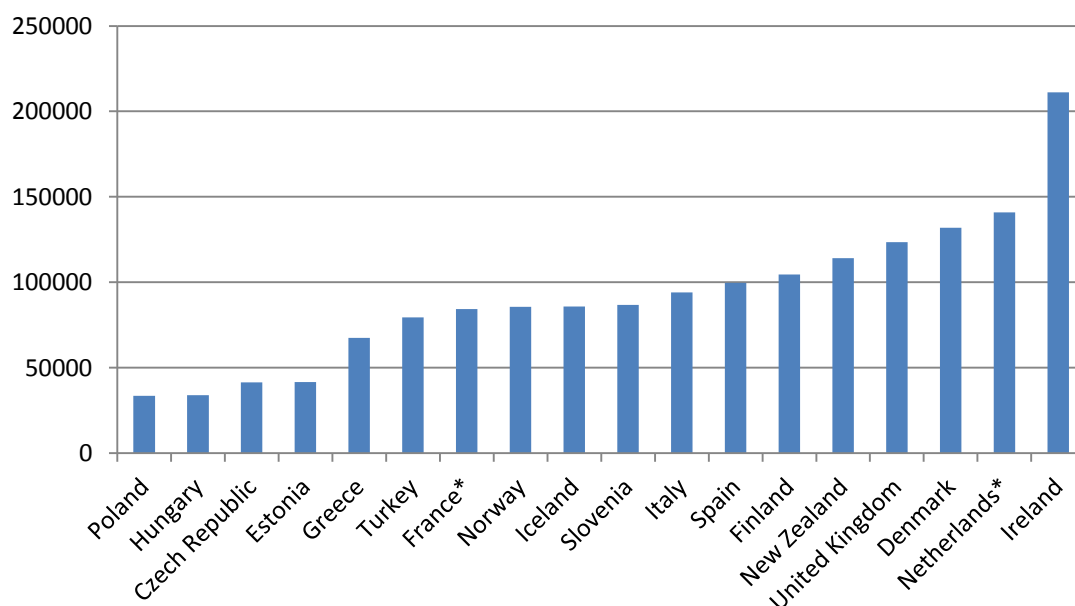
**A prerequisite for DRG-based hospital payment to increase efficiency is purchaser-provider separation with public hospitals acting as semi-autonomous organizations with decision rights at the level of the whole institution (and not just operational management), particularly in terms of managing hospital resources** (Busse et al 2002; Langenbrunner et al 2009). The limited autonomy of Irish public hospitals significantly weakens the effectiveness of the DRG payment system. For example, public HSE hospitals are required to return any under-spend or additional revenue to the State. In contrast, public voluntary hospitals contracted by the HSE are financially autonomous and can retain any surplus and therefore have an incentive to minimise costs (Brick et al 2010). Increased hospital autonomy would also be a prerequisite for a “money follows the patient” policy, to produce the necessary incentives for hospitals to compete for patients on quality.

In the context of the Programme for Government proposals on acute public hospital governance, there are several different types of hospital autonomy in Europe which could serve as a useful model for reforms in Ireland in this area (Saltman and Durán 2011). Under the “restricted autonomy” category (e.g. Norway and some hospitals in Spain) public hospitals have the right to make decisions about closures and capital issues, but the government retains the right of veto. Spain’s Consortia model, as well as some public hospitals in Portugal, Israel, England, Estonia and the Czech Republic fall under the middle category of “considerable autonomy” where hospitals have the right to make substantial structural changes. Finally, with “maximal semi-autonomy” (e.g. private non profit-making hospitals in Netherlands), hospitals have full decision-making autonomy with regard to operational issues, such as hiring/firing staff, initiating/closing services and a wide range of capital, operating, financing and budget issues. While the Irish health system would be likely to benefit from hospital autonomy, there is little international evidence on whether one model is preferable in terms of enhancing efficiency and no obvious trend in Europe, with countries with semi-autonomous public hospital systems moving in both directions across this spectrum (increasing and decreasing autonomy) (Saltman and Durán 2011) as they seek to find the optimal balance of incentives.

## Paying specialists

Hospital physicians in Ireland have considerably higher salaried incomes compared to those in all other OECD countries for which data are available (Figure 5.2). These figures need to be treated with caution since, as discussed above, physician salaries are difficult to compare across countries. However, the data in Ireland are likely to be an underestimate since, unlike in many other countries, they exclude income from private practice. In addition to exceeding physician salaries in other countries, inflation in the salaries of Irish hospital physicians is also likely to exceed inflation in other areas of the Irish health sector and non-health costs, as illustrated by the high rate of inflation of hospital services (Table 2.11). As with GP incomes, **hospital physician salaries therefore appears to be an area in which a reduction in prices could make considerable savings**, although the Public Service Agreement precludes further reform in the near future. As noted however, the recent agreement between the HSE and the IHCA provides for the introduction of a lower salary scale for new entrants.

**Figure 5.2 Salaried incomes of specialists, selected OECD countries, US\$ PPP, 2010**



Source: OECD (2012)

Note: Data from 2009 for countries marked with \*. All data refer to the latest year available.

## **Coordinating hospital, primary and community care**

OECD data on expenditure on health disaggregated by ambulatory and inpatient care are not available for Ireland (OECD 2012). However, data on physical resources reveal that compared to EU averages, Ireland has a low number of hospital beds (314.98 per 100,000 population, compared to the EU average of 545.36 in 2010), specialist physicians (47.16 per 100,000 compared to 83.6) and GPs (56.82 per 100,000 compared to 82.04) and a high number of nurses (1311.86 per 100,000 compared to 834.3) (WHO Regional Office for Europe 2012). There is also a very low number of nursing home and residential home beds, with 585 per 100,000 in Ireland in 2010 compared to 1227.87 in Belgium, 906.83 in France, 1036.51 in the Netherlands, 1423.01 in Sweden and 876.66 in the UK, for example (EU average not available) (WHO Regional Office for Europe 2012). These data indicate a general undersupply of human and physical resources in primary, secondary and community care. An undersupply of primary and community services is likely to reduce efficiency in health service delivery through poor preventive and public health services, delays and/or waiting lists resulting in the need for more expensive treatment for more serious conditions in secondary care and emergency departments. In order to address these issues, **there appears to be considerable scope for enhancing efficiency of delivery in Ireland through improved coordination and integration of existing hospital, primary and community services.**

Internationally, there is abundant evidence that a strong primary care-led health system is associated with improved health outcomes, increased quality of care, decreased health inequalities and lower health-care costs overall (Starfield and Shi 2002; Macinko et al 2003; Shi et al 2005; Starfield et al 2005; Saltman et al 2006). Strong primary care is also an effective driver of integrated hospital, primary and community care (Kringos et al 2010). A systematic review of international evidence finds that quality and efficiency of primary care, equity in health, and costs of care are improved through several key structures and processes (Kringos et al 2010). The three main structures are: supportive governmental policies, universal financial coverage and low or no patient cost sharing in primary care. Primary care in Ireland to a great extent lacks all these structures; while some supportive government policies have

been introduced, many of these are yet to be implemented (see above) and there is no universal financial coverage and fairly high cost sharing as compared to other countries in Europe (see chapter 3). This suggests much could be gained from improvements in these areas and indicates the **urgent need for the Irish Government to continue to implementing the primary care reforms it has proposed.**

The four main processes for enhancing primary care are: access, continuity, coordination and comprehensiveness (Kringos et al 2010). Policy initiatives in Ireland promote some of these processes. For example, as in many other western European countries (van Ginneken 2013), Irish reforms have focused on the development of a team-based approach to the delivery of primary care services (primary care teams, PCTs) which is an important component of coordinated primary care (Kringos et al 2010). There has been a particular focus on diverting care for chronic diseases from acute to primary care settings, thereby expanding the range of health problems for which primary care is provided. This is an important aspect of improving primary care comprehensiveness (Kringos et al 2010). However, the slow development of PCTs has hindered progress on these aspects of primary care.

International evidence points to two further key policy areas which are likely to enhance efficiency in service delivery in Ireland. First, **the high number of nurses and low number of physicians in Ireland suggests there is scope for further development of task-shifting from physicians to nurses.** International evidence suggests skill mix changes can address shortages of certain provider groups and their uneven distribution, reduce costs and increase cost-effectiveness of service delivery and quality of care (Bourgeault et al 2008), as well as strengthening coordination of care (Kringos et al 2010). The development and implementation of advanced practice nursing in the UK provide useful insights that are applicable to other European health systems (Bourgeault et al 2008).

Secondly, **coordination of care in Ireland is hindered by a suboptimal GP gatekeeping system.** Despite evidence demonstrating that strong gatekeeping promotes efficiency and quality of health care through improved coordination

(Kringos et al 2010), several countries in Europe have either no or weak gatekeeping (van Ginneken 2013). Ireland has a formal gate keeping system but it is weak, mainly because there is no obligation to register with a GP, but also due to the current design of user charges policy: while a patient must obtain a referral from a GP before accessing publicly provided secondary care, high user charges for primary care may incentivise people to favour treatment in an outpatient setting over primary care. In contrast, countries such as Denmark, Italy, the Netherlands, Spain and the UK have strong supply-side controls over gate keeping, with compulsory referrals, which are likely to enhance overall coordination of care (van Ginneken 2013). Many countries that do not have formal gatekeeping systems financially reward patients who obtain a referral to specialist care (e.g. Belgium, France, Germany).

### **Quality improvement in hospitals**

A small but growing body of evidence suggests that mechanisms primarily designed to improve quality of care in hospitals also have considerable benefits in enhancing efficiency and reducing costs. For example, using evidence-based clinical practice guidelines has been found to decrease admission rates and length of stay, reduce resource utilisation and reduce costs (Bahtsevani et al 2004). Another important example is the adoption by hospital managers of management tools from the manufacturing industry designed to improve quality, efficiency, and financial performance, such as Six Sigma and Lean. A review found that evaluations of these tools have mainly measured improvements in clinical outcomes and processes of care but that the evidence on the feasible rate of efficiency gains in this area is limited, since the contexts for such initiatives vary greatly and studies often do not measure the cost-effectiveness of these interventions (DelliFraine et al 2010). Nevertheless, there are some indications of efficiency gains in the Netherlands for example, where a concerted effort in a hospital achieved savings of a little less than 2% in one year (van den Heuvel et al 2006).



## Pharmaceutical policies

**Ireland's per capita pharmaceutical expenditure is the highest of all OECD countries except Canada and the USA**, reaching USD686.4 per capita (PPP) in 2010 compared to the OECD average of USD496.0 (2010 or nearest year) (OECD 2012).<sup>64</sup> This suggests considerable scope for reducing costs. Progress towards reducing the cost of medicines in Ireland has focused on price reductions (via reductions to ex-factory prices and wholesale and retail mark-ups). Other areas where efficiency gains could be achieved include: increasing prescribing by international non-proprietary name (INN); promoting generic substitution; and implementing reference pricing. These efficiency-enhancing policies are widely used in many countries across Europe (van Ginneken 2013) and are now contained in draft legislation in Ireland on reference pricing and medicine interchangeability. Alternative strategies in use in other countries, such as competitive tendering for high-volume off-patent pharmaceuticals, could also be considered (Gorecki et al 2012). The recently announced agreement for lower prices of both branded and generic drugs provides possible savings of €400 million over three years, which is around 1% of public health spending.

**To promote generic medicines, there is a growing trend across Europe towards encouraging physicians to prescribe by INN rather than by brand name** (see Table 5.2). Rates of generic consumption are low in Ireland in comparison with other countries, even though INN prescribing is a feature of medical education in Ireland, the Irish Medical Organisation (IMO) recommends INN prescribing, and the Irish Medicines Board (IMB) reassures doctors and patients about the safety and efficacy of generics. In 2011, 26.8 per cent of items dispensed under the GMS Scheme were brand name products with a generic equivalent, whereas in England in 2008 only 5 per cent of items were prescribed by brand when a generic was available (Gorecki et

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<sup>64</sup>OECD figures include spending on non-prescription medicines, as well as spending that is not covered by the various State schemes. However, it is important to note the substantial reductions in public prescription pharmaceutical expenditure that have been achieved since 2008 (see Gorecki et al 2012 for a full description).

al 2012). A change in culture may also be needed, so that both physicians and patients refer to medicines by generic name where possible. Gorecki et al (2012) estimate potential savings of €9m in 2010 if the top 20 drugs (with a generic equivalent) on the GMS scheme (by value) were priced at the lowest generic value. Moran (2010) undertook a similar exercise using the top 100 GMS drugs for 2009 and come up with savings of €55.4m.

**Pharmacists can help control pharmaceutical expenditure if given the freedom to substitute equivalent, cheaper products** (generic or parallel imports) and if economical dispensing practices are promoted through financial incentives. Several countries have permitted substitution by pharmacists during the 2000s (see Table 5.3). However, the scope for savings under the current proposals for reference pricing and medicine interchangeability is dependent on sufficient price competition and controls on the use of ‘no substitution’ prescriptions (Gorecki et al 2012).

**Table 5.2 INN prescribing by physicians, EU-27, 2011**

Policy	Member States
Mandatory	Estonia, Lithuania*, Portugal, Romania
Required where possible	France, Spain
Highly recommended	Austria**, Belgium, United Kingdom***
Plans to introduce	Czech Republic

Source: van Ginneken (2013)

Note: \* where the generic name must be written beside the brand name; \*\* prescribing software offers cheaper substitutes; \*\*\* where medical students are taught to prescribe by INN.

**Pharmacist remuneration should be disconnected from the price of the medicine** (Gorecki et al 2009). The most common forms of pharmacist remuneration in Europe are linear or regressive mark-up schemes (van Ginneken 2013). Some of Ireland’s reimbursement methods (i.e. DPS/LTI/EEA/Health Amendment) maintain a linear mark-up scheme, where community pharmacists earn both a flat fee as well as 20% of the ex-wholesale price. This creates a perverse incentive for pharmacists to dispense the most expensive products in order to earn greater income.

**Table 5.3: Generic substitution by pharmacists, EU27, 2011**

<b>Policy</b>	<b>Member States</b>
Unless doctor opt-out or patient opposition	Czech Republic, Denmark, France*, Finland, Germany, Hungary**, Latvia, Malta, Portugal, Poland, Romania, Slovakia, Sweden
Unless doctor opt-out and with patient's willingness to pay the price differential	Slovenia, Italy
Unless branded at reference price	Spain
Obligated to offer generic	Estonia, Lithuania

Source: van Ginneken (2013)

Note: \* right to substitute from the Generic Registry; \*\* right to substitute from the official list of substitutes

**External reference pricing should allow the prices of medicines in Ireland to reflect internationally competitive prices.** Currently, Ireland allows free pricing for in-patent medicines up to a maximum ex-factory price as determined by a basket of nine EU Member States. Rather than selecting the average price of the basket, cost savings could potentially be realised by using the lowest price in the basket.

### **Competition between insurers offering statutory coverage**

The Programme for Government notes that everyone in Ireland will be able to obtain statutory benefits from an 'insurer' of their choice, including a public option. The assumption is that private insurers operating in the PHI market will compete with a public entity to offer statutory coverage. It might be argued that for a population of about four million people, it would be better to pursue the option of a single purchaser. However, the 'starting point' for Ireland includes a significant PHI market with multiple private insurers.

**Whether or not a competitive insurance system will offer advantages over the current system in terms of the achievement of key health policy goals depends on a range of factors, including capacity to design appropriate institutional arrangements, ability to regulate the market and the availability of good information systems** (Schneider 2009). Particular attention will need to be paid to ensuring that:

- people have equal opportunity to choose insurers; older people and people with chronic conditions should not be disadvantaged by facing higher transaction costs

than others when switching from one insurer to another; this requires regulation and a sophisticated risk adjustment mechanism to compensate insurers for covering people who have a higher risk of ill health

- insurers have incentives to operate as efficiently as possible and do not have incentives to select risks; this requires insurers to bear financial risk and a sophisticated risk adjustment mechanism (van de Ven and Ellis 2000)
- insurers have the tools required for strategic purchasing and are able to use them; this requires good information systems
- incentives are aligned across the health system
- fragmentation is avoided

If these issues are not addressed, it may be difficult for insurer competition to offer the expected advantages in terms of enhancing efficiency and quality in health care administration and delivery. There is also the issue of cost control. The experience of insurer competition in Germany, the Netherlands and Switzerland suggests that it has not been effective in controlling health care costs (Busse 2013 in press; Crivelli 2013 in press; Maarse and Paulus 2011; Schut and van de Ven 2011; Westert et al 2010). Finally, given the fiscal constraints Ireland faces, the resources needed to establish an effective system of competing insurers are unlikely to be available.

## **5.4 Summary**

This chapter has reviewed different ways of improving efficiency in health care delivery. It has focused mainly on areas identified as a priority for Ireland: GP payment, hospital payment and the pricing and reimbursement of pharmaceuticals.

The Irish Government's commitment to strengthen primary care is an important step towards improving efficiency in the health system. Achieving this commitment in the context of large cuts to public expenditure on health presents a significant challenge, however, particularly given the lack of infrastructure in the primary care sector, the under-supply of nursing home and long-stay beds and community services and incentives that favour hospitals.

Nevertheless, efficiency in primary care could be enhanced by:

- Lowering the cost of GP services through greater use of capitation – for example, increasing the capitation share of GP income, making better use of risk adjustment in capitation and considering other innovations in capitation design. Reductions in GMS payments may also promote efficiency by encouraging GPs to delegate some tasks to nurses. One unintended effect of reduced GMS payments might be to increase costs for private patients if GPs seek to compensate for the reduction in their public income.
- Improving the skill-mix; there is considerable scope for an enhanced role for nurses and for rationalising the role of therapists (occupational therapists etc).
- Making more use of supply-side interventions to strengthen gate keeping, rather than addressing overuse of emergency departments and underuse of primary care through user charges. As proposed in the Government's plan to extend entitlement to GP visit cards to the whole population by 2015 under universal health insurance, universal access to primary care with low or no use charges would help to reduce fragmented purchasing in this sector (with payment to GPs from patients, private health insurance and government), which undermines incentives for quality improvement and efficiency.

International comparisons suggest that the public sector in Ireland purchases hospital care for very high prices. Efficiency gains in this sector could be achieved by increasing the share of DRG payment in total hospital payment; reducing DRG prices and, at the same time, permanently lowering the costs of employing specialist doctors.

Increasing care quality and promoting efficiency by shifting service delivery from high cost (inpatient) to lower cost (day case, primary care) settings, where appropriate, could be achieved by:

- Greater use of the DRG system for strategic purchasing – for example, adapting DRG weights to increase or decrease the volume of a particular case or to shift to alternative treatment modalities.
- Collecting better data for monitoring quality (e.g. readmissions data) and ensuring that information systems are linked.
- Developing hospital autonomy in order to enhance provider competition, including addressing hospital budget deficits.
- Further development of best practice guidelines and care pathways through the National Clinical Programmes.

In the pharmaceutical sector there is considerable scope to reduce costs by increasing prescribing by INN, promoting generic substitution and implementing reference pricing.

A major issue is the speed with which efficiency gains are achievable. The benefits of improved incentives and better payment systems cannot materialise until they are implemented and even then experience suggests it takes several years for the full effects to be seen. Estimates of efficiency savings made in Ireland since the start of the recession (net of the effect of cost reductions) suggest these have not exceeded 3% per year (HSE 2012). Evidence also shows that it is difficult to avoid some short- to medium-term negative effects on efficiency at times of substantial organisational change (Hutchings et al 2003). Thus, while there is opportunity for efficiency gains to be achieved through planned reforms, it is not likely that they can be achieved within the next two years.

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## **6 Main lessons and implementation issues**

### **6.1 Introduction**

This report has outlined challenges facing the Irish health system in the context of unprecedented reductions in public spending prompted by the economic situation and the receipt of financial assistance from the EU and the IMF. In discussing how Ireland might meet these challenges, the report has drawn on international experience regarding changes to the level of statutory resources for health; changes to health coverage; and the potential for improvements in health service efficiency.

The need to reduce public spending on health in Ireland has been compounded by underlying cost pressures. Some cost pressures come from within the health sector – for example, very high levels of inflation in health care costs, largely driven by high salaries for some health staff and high drug prices; poorly developed primary and community health services; a model of care that favours hospitals over community services; and reliance on means-tested (‘demand-led’) entitlement to benefits. Other underlying sources of financial pressure – notably substantial and continuing growth in the size of the population and changes in the population’s age structure – are beyond the control of the health sector.

The challenges outlined in the report come from the combined effect of factors within and external to the health sector. Economic recession has caused unemployment to rise and incomes to fall, leading to sharply increased demand for means-tested benefits (including medical cards, GP visit cards and the Fair Deal scheme for nursing home care). Demographic changes have increased the numbers of people needing health and long-term care, but the health system’s care delivery structures have not kept pace with growing demand.

To date, cuts in public spending on health have been achieved mainly through reduced pay for staff, improved efficiency in service delivery and, to a limited extent, increases in the financial burden falling on users (higher user charges and the removal of automatic entitlement to primary care for older people). The problem policy makers now face is to continue to cut public spending on health at a time when the most easily available savings have already been made; there is growing demand for health and long-term care; and the Programme for Government has committed to improving the scope and quality of health services, expanding access to benefits and overhauling health care financing.

The report finds that while there is scope for further efficiency savings, and while the magnitude of potential savings may be sufficient to meet externally imposed health expenditure targets, these savings cannot be made within the externally imposed timeframe – without damaging patient care – unless high salaries and the high price of other inputs are seriously addressed. If this is not feasible, the Government should consider establishing a mechanism to compensate the Department of Health and the Health Service Executive for increased demand on the health sector.

It is also evident that efficiency gains from planned and additional reforms – which will understandably take several years to materialise – will not be sufficient to fund the new political commitments noted above. Given Ireland’s health challenges and its outlier status in terms of health coverage, commitments to establish universal access to primary care and to strengthen service delivery are important steps. To achieve these commitments, however, the health system will require additional revenue.

## **6.2 Statutory resources**

While the level of statutory resources for health in Ireland is broadly in line with levels found in comparable countries, patterns of coverage are unusual in that they fail to provide access to primary care and community services for the majority of the population, and encourage inappropriate use of hospital services. There has also been

a significant increase in reliance on private spending since 2008, with the share of health expenditure coming from statutory sources falling below the OECD average for the first time in over a decade.

It is unlikely that the health policy objectives set out in the Programme for Government can be met without an increase in the level of statutory resources, even if substantial efficiency savings are achieved, particularly given the commitment to expand entitlement and access to subsidised services. In the short term the scope for additional statutory resources is limited, however, with the possible exception of some extra revenues from taxes on health-damaging goods (sin taxes). Ireland already has relatively high taxes on alcoholic drinks and tobacco, but higher taxes for these products can be justified on public health grounds. Extending taxes to other health-damaging goods such as saturated fats and sugary soft drinks might also be justified on health grounds, but experience in this area is limited. Although there are strong public health arguments for sin taxes, there is uncertainty about how much revenue would be raised, and to benefit the health sector the revenue would have to be earmarked.

It might be helpful if targets for lowering public spending on health were set so as to account for growth in service demand that is driven by demographic changes and by sharp increases in the numbers of people eligible for medical cards (caused by the recession). Realistic targets that recognise underlying cost pressures beyond the control of the health sector would be more likely to be met, and the establishment of a mechanism to reflect increased demand would help to maintain adequacy and a greater degree of stability in statutory revenues.

### **6.3 Health coverage**

Universally accessible primary care is the key stepping stone to enhancing equity of access to services and to improving efficiency in service delivery. Primary care needs to be free at the point of use or available at prices that do not deter use. Out-of-pocket payments in the Irish health system are largely concentrated in primary care and

community services, mainly because the majority of the population has no entitlement to publicly financed services. Thus, access to many primary care and community services (such as GP care and physiotherapy) is essentially a commercial transaction between patient and health care professional.

If the burden of financing health care is shifted onto service users, it will have the greatest effect on people with low and middle incomes. Increasing the burden on service users also makes it more difficult to improve efficiency in service provision, particularly where the incentives facing both providers and users encourage the use of higher cost or less appropriate forms of care. Thus, at a time when statutory resources for health are being reduced, there remain arguments for these resources to be maintained on efficiency grounds. This is in addition to the strong equity case for allowing some increase in spending on means-tested services.

Strategies to increase the share of resources coming from existing user charges in primary care are limited by the fact that many charges already represent the full cost of care. Where partial government subsidies exist (for example, in the Drugs Payment Scheme), these have been reduced significantly in recent years, so the level of user charges has already risen. This leaves a clear dilemma: to increase user charges for primary care is likely to undermine efforts to put in place incentives to shift from secondary to primary care, to increase the coherence and integration of care pathways and to increase equity in the health system.

The relatively lower user charges applied in the public hospital system fall mainly on the small number of people without medical cards and without private health insurance (although in effect those with private health insurance pay these user charges through their insurance premiums). Any increase in secondary care user charges would therefore fall disproportionately on this potentially vulnerable part of the population just above the threshold for medical cards, a group of people studies have shown to be the most disadvantaged in terms of the user charges they face and access to care. These people are also relatively sensitive to the level of user charges, and increases may lead to undesirable changes in the use of health care.



Increasing user charges for private care in public hospitals would increase overall prices for private health insurance, would price some people of the private health insurance market and would place a greater burden on lower-income people with private health insurance. However, it might generate revenue for the health system without hitting the most vulnerable people. The key may be for any change to be gradual enough to avoid destabilising the private health insurance market. An increase in the numbers of cases for which public hospitals can bill private insurers would increase revenues for hospitals and only have modest effects on the premiums charged. The eventual goal of government policy for all hospital funding to come from insurance would be an extension of this system.

It inevitably appears perverse to reduce health coverage when the declared policy is to increase it. Substantial increases in user charges or reductions in population or service coverage are likely to be seen as moving in the opposite direction to stated policy. To a great extent the problem is the rate at which savings are expected to be achieved, and the difficulty of accommodating these entirely through increased efficiency. Since planned changes to health care financing will shift the mechanism from government to private insurers, it may be possible in the short run to shift some of the financing burden to private health insurance as part of the pathway to a more comprehensive universal health insurance system.

#### **6.4 Improving health services efficiency**

There is good evidence of substantial scope for enhancing efficiency in the Irish health system; comparing the best and worst within Ireland reveals potential for significant improvements, and international comparisons show further potential. Experience suggests that where there is scope for savings they can be achieved at a rate of 2-3 per cent per year with little disruption to services, but attempts to achieve savings more rapidly tend to affect service delivery (usually disproportionately to the savings achieved). If health needs in the population were unchanged, it would probably be feasible to achieve the required cost reductions through improvements in

efficiency (including adjustments to staff pay and non-staff input prices). It is not feasible on the planned trajectory.

The early signs for 2012 suggest that only around half of the necessary savings are achievable without reductions in service levels. The proposed savings in 2013 are smaller, but there may be a need to make good some of the deficits for 2012, so the challenge in 2013 may be similar to that in 2012. The probable outcome would again be a failure to meet the targets fully or reductions in the provision of services. On a slightly longer trajectory, however, the planned savings appear to be more achievable. As suggested above, it would be easier to focus on managing efficiency gains and lowering costs if the uncontrollable cost drivers were addressed separately.

In addition to increases in efficiency within current models of provision, there is substantial scope for improvement from changing the way in which services are delivered. Such changes are envisaged in current reforms and should in time bring opportunities to reduce overall costs and to expand coverage. However, the scope for savings in the next two years from this kind of change is limited by the speed at which new models can be put in place and (importantly) start to operate efficiently. There are particular difficulties in releasing savings where staff cannot be moved quickly to new settings or have inappropriate skills for the new models of service.

More day case work, shorter lengths of stay and better management of existing hospital capacity can produce savings quickly, but this needs mechanisms to withdraw the resources saved (and not simply to use them to make good identified deficiencies in current provision). Some of the larger potential efficiency gains will need changes in payment mechanisms and related incentives and investment in new facilities, skills and processes. As suggested above, it is realistic to seek savings of the scale necessary by such means, but the likely timescale for the adjustment will be longer than is set out in current spending plans.

Paying less for drugs and other non-staff inputs offers substantial potential for savings, and this is already being actively pursued by the Department of Health and the HSE. Savings from lower prices for both branded and generic drugs will make a

useful if modest contribution. There is scope for further reductions in the prices paid for drugs beyond recent price cuts, but this will involve additional negotiation.

Further savings could be achieved from more careful and cost conscious prescribing, but this requires investment in training, decision support and other behaviour change interventions. More attention should be given to increasing prescribing support to encourage the use, where appropriate, of the lowest cost drugs for effective treatment of diseases. This may be particularly important given that demographic change will increase the number of people with chronic diseases and the associated need for drugs. Careful prescribing will limit the pressure on costs from this source.

The current Public Service Agreement does not permit further reductions in rates of pay for existing staff or compulsory redundancies. The restrictions on employing staff is an extra constraint on the achievement of savings through (for example) reduced levels of agency staff employment. While these restrictions remain there is an inevitable limit to the pace at which staff costs overall can be reduced, since low levels of recruitment mean that new staff (on lower pay) represent only a small proportion of total staff. While the current agreement may allow short term gains from greater productivity and efficiency, in the longer run it will be important to allow for changes in skill mix and service configuration to achieve the larger potential gains in efficiency.

A key problem lies in the imbalances in the structures and functions of the health system in Ireland. Over the last decade, salaries and other input prices (e.g. drugs, appliances) rose to higher levels than in comparable countries, and long-standing deficiencies in the skills and infrastructure base were not made good. Current incentive structures encourage inefficiency in the use of skilled staff, and entitlement structures lead to inefficiencies in the use of some services. The health reforms envisaged in the Programme for Government aim to remove these imbalances, and should allow for a more coherent and efficient use of resources, while longer-term measures to reduce the cost base may allow many of the improvements in access and quality of services to be achieved without proportionate increases in cost. There is a risk that measures to meet the current targets could make it more difficult to achieve

the first stages of improvement in services and to prepare the way for a system of universal benefits based on need.

### **6.5 Achieving improved efficiency and lower costs at a time of change**

The Irish Government has embarked on an ambitious programme of reform in the organisation and delivery (and, in future, in the financing) of health services. This follows a programme of reforms involving the establishment of a centralised management structure. While many current (and indeed past) structures have shortcomings, research shows that it is difficult to achieve lower costs and increased efficiency when structures are subject to radical change. Studies suggest that efficiency tends to go down at times of structural reorganisation and may take three to five years fully to recover, so careful consideration is needed to achieve sufficient stability while savings are sought (see chapter 2). The Government has appropriately placed great emphasis on the need for management to be held accountable for the use of resources and for service delivery, and it will be important to ensure that responsibilities remain clearly defined during the transition to new management structures and that there is no avoidable destabilising of delivery organisations.

### **6.6 Maintaining a focus on policy goals**

Two important objectives of the proposed changes in the financing and delivery of health care in Ireland are to improve efficiency and the appropriateness of care and to secure access to care on the basis of need (rather than ability to pay). Measures to reduce entitlements and to increase user charges generally run counter to these objectives, although there is some scope for increasing revenue from increases in secondary care charges for privately insured patients.

The scope for efficiency savings is adequate to achieve the current planned reductions in spending, although probably not sufficient to accommodate growing demands from population growth and ageing and desirable improvements in access and quality of

care. However, savings cannot be made within the required timeframe without damaging patient care. The extent to which a longer time scale is needed will depend in part on success in reducing staff costs (through lower salaries for new staff and measures to speed up changes in staff levels and configuration) and paying lower prices for drugs and other inputs.

Reduced public spending on health services in 2012 and 2013 comes after several years of cuts and organisational changes. To achieve the planned changes will require stronger management of service delivery and organisational stability to ensure clear lines of responsibility and accountability.