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# TOWARDS UNIVERSAL HEALTHCARE IN IRELAND – WHAT CAN WE LEARN FROM THE LITERATURE?

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## ABBREVIATIONS

HIE	Health insurance experiment
HSE	Health Service Executive
NHS	National Health Service (UK)
NICE	National Institute for Health and Care Excellence (UK)
OECD	Organisation for Economic Co-operation and Development
PHI	Private health insurance
SDG	Sustainable development goals
SHI	Social health insurance
UHC	Universal healthcare
UHI	Universal health insurance

## EXECUTIVE SUMMARY

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Ireland remains an anomaly in Europe in not providing universal healthcare. In 2017, an all-party parliamentary committee published a report (the Sláintecare report) recommending the establishment of a high quality, universal public healthcare system for Ireland. The report recommended the introduction of universal GP and primary care, ending private practice in public hospitals, reducing or removing out-of-pocket fees and substantially increasing public healthcare expenditure and capacity in a tax-funded system. While there has been some progress in implementing the proposals set out in the Sláintecare report, much more is required to move towards universal healthcare in Ireland.

The aim of the analysis in this report is to review the national and international literature on universal healthcare to identify if there are lessons for Ireland as it seeks to move towards a universal healthcare system.

The analysis identified three key lessons:

First, as a starting point a definition of universal healthcare is required. While the term universal healthcare is commonly used both in Ireland and elsewhere, it is somewhat unclear what is actually meant by the term. Definitions and interpretations can and do differ widely. An explicit definition will provide a starting point for thinking about what a universal healthcare system might look like in practice and will help identify appropriate metrics for its measurement. Within the Sláintecare report there is ambiguity about what definition of universal healthcare is implied and what a universal healthcare in Ireland might look like in practice. This includes the role that user charges and private health insurance (PHI) would play in a universal system.

Second, there are different dimensions to universal healthcare. When moving towards universal healthcare it is likely there will be trade-offs between increasing population coverage, service coverage and/or cost coverage (e.g. the proportion of the cost that is covered by the patient). No healthcare system achieves 100 per cent coverage of the total population for all potential healthcare services at no cost to users. In addition, reform proposals such as universal GP care could improve cost coverage; however, if there are not a sufficient number of GPs to meet the additional demand that would arise from its introduction, then the availability or timeliness of services may be negatively impacted.

Third, there is no one way to achieve universal healthcare; however careful consideration of the role of PHI in a universal healthcare system is required. While a proportion of healthcare is financed by PHI in many universal healthcare systems, what is unusual in Ireland is the size of the PHI market in terms of the proportion of the population covered by PHI and relatedly the degree of regulation. Previous research has shown that achieving universal healthcare through the extensive use of PHI can give rise to a number of potential issues including inequitable access to healthcare services and high administrative costs among insurers, which are likely to be passed on to consumers.



## CHAPTER 1

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### Introduction

Universal healthcare is increasingly being endorsed as a priority goal for healthcare systems around the world (Garrett et al., 2009). However, healthcare system reforms aimed at achieving universal healthcare can be traced back to the emergence of organised healthcare in the 19th century (McKee et al., 2013; Abihiro and De Allegri, 2015). Moves towards achieving universal healthcare first started in Germany and later spread through other parts of Europe including the United Kingdom, France and Sweden (McKee et al., 2013; Abihiro and De Allegri, 2015). Accompanying the move towards universal healthcare was a growing interest in a right to health. In 1948 the WHO Constitution recognised that:

*the enjoyment of the highest attainable standard of health is one of the fundamental rights of every being without distinction of race, religion and political belief, economic or social condition* (World Health Organization, 1948).

Some 30 years later in 1978, the declaration of the Alma Ata conference on primary healthcare recognised health and access to basic healthcare services as fundamental human rights (World Health Organization, 1978).

Despite adopting the declaration of the Alma Ata, Ireland remains an anomaly in Europe in not providing universal healthcare. Recognising the need to reform the Irish healthcare system, in 2011 a newly elected Government committed to a universal healthcare system, financed by universal health insurance (UHI) (Department of the Taoiseach, 2011). This was the first time in the history of the Irish State that there was a political commitment to the introduction of universal healthcare. Although in 2015 the reform proposal was abandoned on cost grounds (Department of Health, 2015), the idea of universal healthcare for Ireland was now firmly on the political agenda. In 2016, an all-party parliamentary committee was established with the aim of achieving a long-term vision for healthcare and the direction of healthcare policy in Ireland. The committee's final report (the Sláintecare report), published in May 2017, noted the need to move towards equitable access to a high quality, universal public healthcare system for Ireland (Houses of the Oireachtas Committee on the Future of Healthcare, 2017).

While some important steps towards universal healthcare have been achieved in recent years including the abolition of public-inpatient charges, much more is required to move towards universal healthcare in Ireland. Delivering a universal healthcare system in practice will be a complex and time-consuming process which requires a coherent pathway, accompanied by strategies to achieve public and

stakeholder support for this pathway (Connolly and Wren, 2019). To date, there has been relatively little analysis of how best to transition from the current, complex public/private provision and financing system which has dominated in Ireland over the past four decades to a universal healthcare system.

The aim of this report therefore is to identify lessons for the achievement of universal healthcare in Ireland. The report includes a narrative review which seeks to summarise some of the national and international literature on implementing universal healthcare. Initially, a number of significant overview pieces on universal healthcare were reviewed in order to identify relevant themes and issues associated with the implementation of universal healthcare. Subsequently, databases, including PubMed and Google Scholar, were searched to identify relevant peer-reviewed literature within particular themes. Studies were also found by reviewing references of relevant publications. In the main, the review was limited to studies published since 2000 in the English language. In addition, while some studies relating to low- and middle-income countries were reviewed and included in this report, the focus of the review (and relevant studies) is on high income countries.

Chapter 2 will identify and discuss some general considerations about universal healthcare including the meaning and rationale of universal healthcare. Chapter 3 will examine alternative approaches to achieving universal healthcare. Chapter 4 will identify lessons for Ireland.

## CHAPTER 2

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### Universal healthcare – some considerations

#### 2.1 INTRODUCTION

When the idea of universal healthcare is widely discussed in academic, policy and public domains, often there is little consideration of some important aspects of universal healthcare, including the precise meaning of the concept, the reason for introducing universal healthcare and how best to identify or measure universal healthcare. This chapter examines each of these areas in turn.

#### 2.2 WHAT IS UNIVERSAL HEALTHCARE?

While the term universal healthcare is commonly used, it is somewhat unclear what is actually meant by the term. Definitions can vary widely. Having undertaken a systematic review of the literature to identify the commonly understood meaning of universal healthcare, Stuckler et al. (2010) note that, in general, authors writing about high-income countries refer to *universal healthcare* while for low-income countries the term *universal coverage* is commonly used. Other terms are also used in relation to universal healthcare including *universal health coverage* and *universal health system*. Often the terms are used interchangeably and without definition. For example, Stuckler et al. (2010), having reviewed 100 papers dealing with universal health coverage found that only 21 of the papers included an explicit definition of the term. They note that there was little consensus across the studies in the definition of universal health coverage and the meanings were often unclear.

Noting the importance of defining universal health coverage, O'Connell et al. (2014) suggest that each individual term – universal, health and coverage – be defined in turn. They suggest that each of the three terms is somewhat contentious and open to interpretation. For example, health could have a narrow interpretation which relates to a limited set of essential health services or could be understood more broadly to include the wider determinants of health such as childhood nutrition and education. Similarly, the term coverage is often associated with access to health services but could go beyond access to consideration of the utilisation of appropriate and high-quality services.

The absence of a clear consensus on the conceptual definition of universal health coverage has resulted in various interpretations of the concept (Abihiro and De Allegri, 2015). For example, there is overlap but not complete agreement between the European Union (EU) and World Health Organization (WHO) definitions of universality. The EU, for example, has accepted 'the overarching values of universality, access to good quality care, equity and solidarity' as 'the common

values and principles that underpin Europe’s health systems’ (Council of the European Union, 2006; 1) and go on to note that:

*Universality means that no-one is barred access to health care; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need regardless of ethnicity, gender, age, social status or ability to pay (Council of the European Union, 2006; 2).*

A commonly used definition of universality is that of the WHO, which has defined its goal of universal health coverage:

*to ensure that every individual and community, irrespective of their circumstances, should receive the health services they need without risking financial hardship (World Health Organization, 2017; xi).*

Underlying the WHO interpretation of universal health coverage, Abihiro and De Allegri (2015) note, is a legal right to health. Reviewing the literature on universal health coverage, they identify a group of scholars that argue that the concept of universal health coverage implies the existence of a legal framework to ensure that every resident gets access to affordable healthcare. The goal of universal health coverage and the responsibility of moving towards it therefore need to be mandated by national law (Kutzin, 2013; Ooms, 2014). However, reviewing the situation across 194 countries, Backman et al. (2008) found that only 56 countries that have ratified the International Covenant on Economic, Social and Cultural Rights (a multilateral treaty adopted by the United Nations General Assembly on 16 December 1966 which confers a right to health) include the right to health in their constitution or other statute. The authors note that international recognition of the right to health is substantially more widespread than national recognition – probably because international accountability is weaker than national accountability (Backman et al., 2008).

In addition to a legal right to health, Abihiro and De Allegri (2015) argue that advancing universal health coverage requires interaction across three dimensions – population coverage, financial protection and access to services. Universal population coverage implies that healthcare is provided to all, with particular attention paid to ensure the inclusion of poor and vulnerable groups (Kingston et al., 2010; Allotey et al., 2012; O’Connell et al., 2014). However, care is required to ensure that where healthcare is offered to all, there are sufficient resources available to deliver quality care for all the population. Ensuring financial protection is an important component of achieving universal health coverage. A guaranteed financial protection requires the implementation of a healthcare financing mechanism that does not require direct (substantial) out-of-pocket payments for healthcare at the point of use (Abihiro and De Allegri, 2015). As a result, the WHO

has endorsed financing healthcare from pooled, prepaid mechanisms such as tax revenue, social health insurance and private health insurance (World Health Organization, 2005). However, according to the WHO definition, universal health coverage does not mean that healthcare is always free of charge but rather that out-of-pocket payments are not so high as to deter people from using services and causing financial hardship (World Health Organization, 2017). In terms of access to services, Abihiro and De Allegri (2015) discuss the package of services to be covered in a universal system. While some argue for a comprehensive set of healthcare services (in line with a broad interpretation of the concept of health) (World Health Organization, 2010), others have taken a more pragmatic view and advocated the provision of a minimum basic package to cover priority health needs, especially in low-income countries (Sachs, 2012). A number of scholars have called for a focus on primary care (World Health Organization, 2008; Yates, 2009; Stuckler et al., 2010), though the interpretation of primary care can differ. Across high-income countries, the package of services covered is usually relatively comprehensive; however, there are differences across the countries in the provision of some services, in particular dental and long-term care.

Defining universality in healthcare, while difficult, is only the first step in moving towards a universal healthcare system. Definitions do not provide blueprints for the implementation of a universal healthcare system (Stuckler et al., 2010) and extensive work is required to identify how to operationalise universality within a particular system (See Chapter 3).

## **2.3 RATIONALE FOR UNIVERSAL HEALTHCARE**

Countries adopt universal healthcare for a variety of reasons; however, a compelling case for universality in healthcare derives from a concern with fairness (Voorhoeve et al., 2016) and a belief that people should have access to healthcare regardless of their ability to pay. Underlying this is a belief that consuming healthcare has a positive impact on health status. In addition to the impact on health status, there are also other potential benefits to introducing universal healthcare. The WHO, for example, in arguing for universal healthcare, identifies three reasons for its introduction – health benefits, economic benefits and political benefits (World Health Organization, 2013).

### **2.3.1 Health benefits**

While health status is influenced by a range of social, economic and genetic factors in addition to healthcare (Dahlgren and Whitehead, 1991), the role of advances in medical treatment in improving health and extending lifespan has been recognised (Cutler, 2001). However, identifying the impact of healthcare in improving population health is somewhat difficult given that access to healthcare is often highly correlated with other factors including national income, welfare expenditure and other indicators of quality of life at a societal level.

Moreno-Serra and Smith (2012) reviewing the evidence on the link between the expansion of universal health coverage and population health outcomes, found some tentative evidence that broader health coverage can lead to better access to necessary care and improved population health; however, they note that the available evidence base is limited by data and methodological constraints and that further research is required to better understand the ways in which the effectiveness of extended health coverage can be maximised, including the effects of factors such as the quality of institutions and governance.

In a study comparing a system with universal healthcare (England) and a system without universal healthcare (US), Dalton et al. (2014) examined whether health system differences between the two countries influenced the quality of hypertension management and disparities across socio-economic position. They found no significant differences in aggregate achievement of clinical targets in relation to hypertension management; however, socioeconomic disparities in blood pressure control were significant in the US but not in the UK. They note that moving towards universal health coverage in the US may reduce disparities in hypertension management. In 2008, the state of Oregon in the US established the Oregon Health Insurance Experiment which drew names by lottery for its Medicaid program for low-income, uninsured adults (Allen et al., 2013). While Medicaid coverage was associated with greater use of healthcare services (Finkelstein et al., 2012), the impact on health status was somewhat ambiguous with a recent analysis finding no effect on the measured dimensions of physical health (Allen and Baicker, 2021).

While the WHO definition of universal health coverage does not preclude the use of out-of-pocket payments for healthcare services, a number of studies have examined the impact of such charges on health status. Such studies are suggestive that low-income people are at greater risk than higher-income people in terms of poor health outcomes due to increased cost sharing (Swartz, 2010). Evidence that user fees prevent access to necessary healthcare emerged from the RAND health insurance experiment in the US in the 1970s, which found that user out-of-pocket payments reduced the use of all types of healthcare services, deterring effective and ineffective treatments to the same extent (Shapiro et al., 1986), and reduced the demand for healthcare services more for low-income groups, and in particular for low-income children (Lohr et al., 1986). A review on the behavioural effects of co-payments for healthcare found mixed evidence on the impact of such co-payments (Kiil and Houlberg, 2014). The majority of the reviewed studies found that co-payment reduces the use of prescription medicine, consultations with GPs and specialists, and ambulatory care; however, the review found no significant effects of co-payment on the prevalence of hospitalisations. The authors found relatively few studies that examined the health effects of co-payment, of which

half did not find any significant effects in the short term. However, the evidence indicates that individuals with low income and in particular need of care generally reduce their use relatively more than the remaining population because of co-payments.

### **2.3.2 Economic benefit**

There are economic benefits for both society and the individual from improvements in health status. The EU has recognised health as a precondition for economic prosperity (European Commission, 2013). Recent analysis by Ozyilmaz et al. (2022) found that health expenditures positively affected economic growth in 21 of 27 European countries examined; in addition, government health expenditure relative to private health and out-of-pocket expenditure was the most important component for economic growth. In low and middle-income countries, the returns on investing in health are significant (Jamison et al., 2013). For example, Jamison et al. (2005) estimated that about 11 per cent of economic growth in low- and middle-income countries in the period 1970-2000 resulted from reductions in adult mortality.

At the individual level, better health is generally associated with higher income (Jamison et al., 2013), though the exact mechanisms underlying this relationship are unclear (Thomas and Frankenberg, 2002). Also at the individual level, people can be protected from high out-of-pocket healthcare expenditure through the extension of universal healthcare (World Health Organization, 2013). In Mexico, for example, recognising the negative impact of high out-of-pocket payments on the health and economic wellbeing of households, the Government introduced a national protection programme largely financed through general taxation (Knaul et al., 2012). Within a decade, the programme resulted in a reduction in the incidence of catastrophic expenditure (generally defined as out-of-pocket spending on healthcare exceeding a household's ability to pay) from 3.1 per cent to 2.0 per cent and a reduction in impoverishment due to healthcare expenditure from 2.2 per cent to 0.8 per cent (Knaul et al., 2012). The potential economic benefits of reducing out-of-pocket healthcare expenditures are however not limited to low and middle-income countries. In the US, for example, 62 per cent of all bankruptcies in 2007 were attributable to medical problems (Himmelstein et al., 2009). Within Europe, while the overall incidence of catastrophic healthcare expenditure is relatively low (World Health Organization, 2017), there is evidence of catastrophic expenditure among certain groups including older people with chronic conditions (Arsenijevic et al., 2016). While levels of catastrophic healthcare expenditure are very low in Ireland, there is some evidence to suggest that the proportion of the population experiencing catastrophic expenditure has increased over time (Johnston et al., 2020).

### **2.3.3 Political benefits**

Discussing the potential political benefits of successfully introducing universality in healthcare, the WHO notes that achieving universality can be a vote winner (World Health Organization, 2013). Many major universal health coverage initiatives have come from political leaders in the run-up to elections and immediately following a transition of power, including the development of the National Health Service (NHS) in 1948 in the UK following the Second World War, and the expansion of universal coverage in Thailand in 2001 following a change of government. However, a note of caution is also raised, as making promises in relation to universality that cannot be kept is often regarded as worse than making no promises at all (World Health Organization, 2013).

At a societal level, universal healthcare implies a sense of solidarity and interconnectedness as members agree to pool resources to help ensure access to healthcare for those who need it (Borgonovi and Compagni, 2013). While difficult to quantify the positive effects of this solidarity, Borgonovi and Compagni (2013) note that a lack of universal healthcare can have negative social consequences at both an individual and community level. At the individual level for example, those that are not covered may have a sense of social exclusion and distrust of public institutions. While at the community level, a lack of universal healthcare can lead to lower levels of social capital and distrust (Miller et al., 2004).

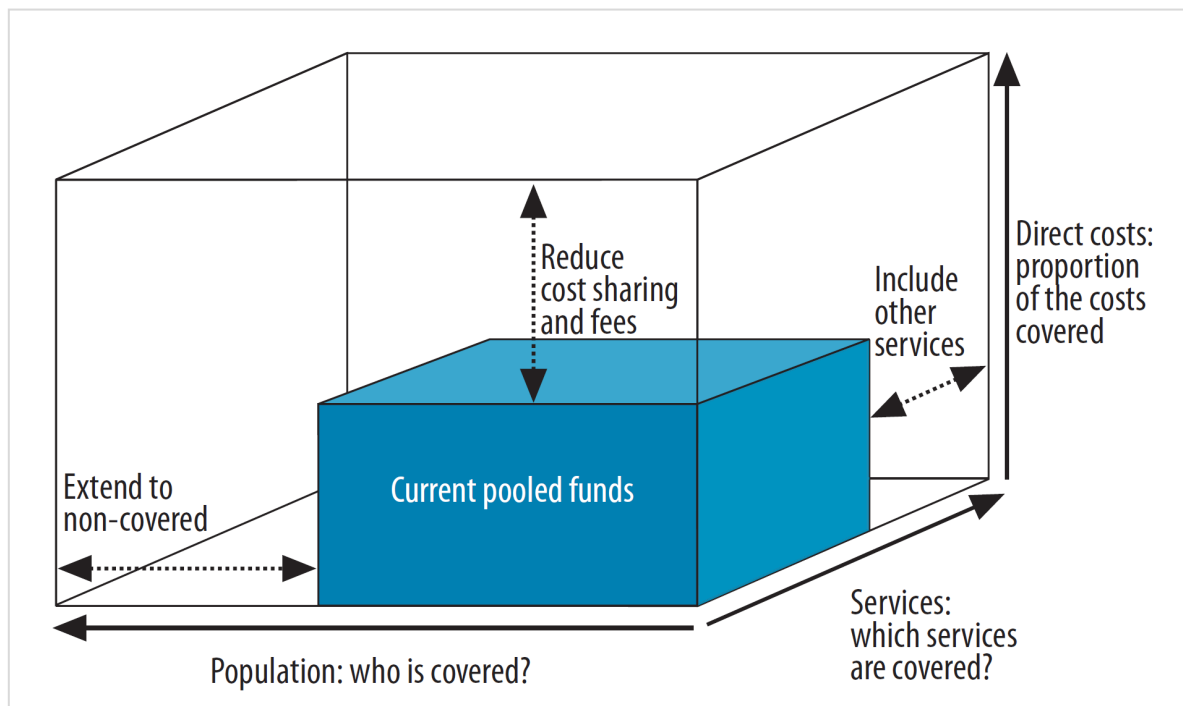
## **2.4 MEASURING UNIVERSAL HEALTHCARE**

Effectively monitoring universal healthcare has become increasingly important, especially given its ascent in policy dialogue (Fullman and Lozano, 2018). This section provides an overview of some methods which have been used to measure progress towards universal healthcare.

### **2.4.1 The Universal Coverage Cube**

The World Health Organization has developed a framework to define and monitor the objectives and achievements of a universal system – the Universal Coverage Cube (Figure 2.1) (World Health Organization, 2010). Conceived by Busse et al. (2007), the cube captures a space with three dimensions: population coverage, service coverage and cost coverage. The cube can be used to graphically depict how many people received various healthcare services of sufficient quality and how much they had to pay (Kutzin, 2013).



**FIGURE 2.1 THE UNIVERSAL COVERAGE CUBE**


Source: World Health Organization (2010).

The box labelled ‘current pooled funds’ shows the situation (at a particular time and space) where approximately half the population is covered for about half of the possible services but where less than half the cost of these services is met from public/pooled funds. To get closer to universal coverage, the country would need to extend coverage to more people, offer more services, and/or pay a greater part of the cost from pooled funds (World Health Organization, 2010). In some high-income countries, the current pooled funded box fills most of the space but no country, including those said to have achieved universal healthcare, covers 100 per cent of the population for 100 per cent of available services for 100 per cent of the cost with no waiting lists (World Health Organization, 2010). Each country fills the box in its own way, trading off services and the proportion of the costs to be met from pooled funds (World Health Organization, 2010).

One criticism levied at the Universal Coverage Cube is that it does not include disparities in coverage across population groups (Roberts et al., 2015). Roberts et al. (2015) therefore suggest a supplementation to the cube (representing national averages) with a step pyramid diagram that would depict the different circumstances encountered by different population groups. They argue that such a depiction would allow policymakers to see which income groups are covered by pooled funds, to what degree and for what different healthcare services. This could then be used to identify which population groups or services the government should try to expand first and to what degree.

While the cube is useful for conceptualising universality and for policymakers to realise that they may need to make trade-offs across the three dimensions, there is a need for measurable indicators that can track universal health coverage in practice (Leegwater et al., 2015). In addition, the cube could depict a situation where there was close to universal coverage (e.g. the majority of the population with eligibility for a wide range of services at relatively low cost to the individual). However, in reality, barriers to access such as long waits or lack of availability of particular services within some areas may mean that in practice there is not universal coverage.

#### **2.4.2 The WHO approach to measuring universal healthcare**

Given that there are considerable differences in the definition and interpretation of universality, it is perhaps unsurprising that there is a lack of clarity about how to measure progress towards universal health coverage (Wagstaff et al., 2016). In recent years there has been increasing interest in, and an increasing literature on, measuring universality across and within countries. However, measuring universality is complex and there is no one framework or set of indicators which will be applicable to all healthcare systems through time.

Building on the WHO's definition of universal health coverage:

*to ensure that every individual and community, irrespective of their circumstances, should receive the health services they need without risking financial hardship* (World Health Organization, 2017; xi),

many studies have included two key elements when assessing universality – service coverage and financial protection. Both must be measured together to obtain a clear picture of those who are unable to access healthcare and those who face financial hardship due to spending on healthcare.

##### ***Service coverage***

In general, service coverage refers to individuals receiving needed healthcare, including preventive treatment. A distinction is sometimes made between service coverage and effective service coverage. Service coverage is defined as the proportion of people in need of a service that receive it, while effective service coverage is defined as the proportion of people in need of services who receive services of sufficient quality to obtain potential health gains (World Health Organization, 2017). While effective service coverage is the preferred indicator, in reality service coverage indicators are more commonly used than effective coverage indicators due to a lack of available data on effective coverage indicators.

Given that it is not feasible to include all potential services for all individuals, a choice must be made about which indicators to include when assessing service

coverage. Boerma et al. (2014a) identify a number of pertinent observations about the choice of indicators. They note that indicators should be selected based on objective considerations and designed to keep the numbers of indicators small and manageable while covering a range of healthcare interventions. Considerations for the selection of indicators include epidemiological relevancy, cost-effectiveness, ease of measurement and communication. They argue that special attention needs to be paid to quality of services, either through the indicator itself or through additional indicators on quality of services or health impact of the intervention.

### ***Financial protection***

A key component of universal healthcare is that people do not suffer financial hardship from accessing needed healthcare services. The WHO recommends two measures for assessing progress towards financial protection; the incidence of catastrophic healthcare expenditure, and the incidence of impoverishment resulting from out-of-pocket payments for healthcare (World Bank Group and World Health Organisation, 2014). While the concept of catastrophic spending is clear, its application has varied in terms of how a household's available resources are calculated and how much of these resources have to be spent on healthcare to cause a catastrophic event. In terms of available resources, catastrophic healthcare expenditures have been defined as healthcare expenditures exceeding a share of either total expenditure, non-food expenditure or expenditure net of basic food needs; while the threshold at which healthcare payments become catastrophic has ranged from 10 to 40 per cent (Saksena et al., 2014). Impoverishment due to out-of-pocket payments has been defined as occurring when out-of-pocket payments push a household below or further below the poverty line. A choice is involved in selecting a poverty line. Both absolute and relative poverty lines exist. The main advantage of an absolute poverty line is that the level of poverty can be monitored over time, however a relative poverty line has the advantage that it can account for different patterns in expenditure across countries (Saksena et al., 2014).

While useful in measuring progress towards financial protection, some caution is required with the proposed measures. For example, the direct medical cost of seeking care is only one potential barrier to financial protection and therefore a good estimate of catastrophic expenditure would also include other non-medical costs such as the cost of travelling to healthcare facility and lost earnings (Abihiro and De Allegri, 2015). In addition, the two measures only capture healthcare costs incurred and therefore do not include healthcare foregone for financial reasons (World Health Organization, 2010; Abihiro et al., 2014).

In 2013 the WHO and World Bank announced a collaborative effort to develop a monitoring framework to support countries in tracking their progress towards the goal of universal healthcare. This led to the publication of a discussion paper in December 2013 (World Bank Group and World Health Organization, 2013) and the

launch in 2014 of the WHO-World Bank global monitoring framework for universal health coverage (Boerma et al., 2014b; World Bank Group and World Health Organization, 2014). Based on the concepts of service coverage and financial protection, the first joint report by the World Bank and the World Health Organization on progress towards universal health coverage was published in 2015 (World Health Organization, 2015), with a more recent report published in 2017 (World Health Organization, 2017).

In the 2017 report, the World Bank and the World Health Organization track universal health coverage using a definition of universal health coverage emanating from the sustainable development goals (SDGs). SDG 3 focuses specifically on ensuring healthy lives and promoting well-being for all ages. Target 3.8 of SDG 3 – achieving universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all – was used as a basis for assessing universal health coverage across countries (World Health Organization, 2017). Target 3.8 has two indicators – 3.8.1 on coverage of essential healthcare services and 3.8.2 on the proportion of a country's population with catastrophic spending, defined as large household expenditure on healthcare as a share of household total consumption or income. Both must be measured together to obtain a clear picture of those who are unable to access healthcare and those who face financial hardship due to spending on healthcare.

A universal healthcare service coverage index – a single indicator computed from indicators of coverage of essential services – was developed to monitor SDG indicator 3.8.1. The index was developed using 16 indicators – four from each of the following areas: reproductive, maternal, newborn and child health; infectious diseases; non-communicable diseases; and service capacity and access. Indicator examples include one-year-old children who have received three doses of diphtheria-tetanus-pertussis; people living with HIV receiving anti retro-viral treatment; cervical cancer screening among women aged 30-49 years and health professionals per capita.

In relation to Target 3.8.2, the WHO assesses the incidence of catastrophic spending on healthcare and impoverishing spending on healthcare (World Health Organization, 2017). Different studies adopt different approaches to measuring catastrophic healthcare expenditures. For example, some studies relate healthcare expenditures not just to income or consumption, but rather to income or consumption less a deduction for necessities, the argument being that this may provide a better measure of households' ability or capacity to pay out of pocket for healthcare services (World Health Organization, 2017). In the 2017 report, two approaches are used: no deduction for necessities and a deduction for actual food spending. The incidence of catastrophic spending was estimated on the basis of

out-of-pocket expenditure exceeding 10 and 25 per cent of household income or consumption.

Impoverishment was defined as occurring when a household's consumption including out-of-pocket spending is more than the poverty line but its consumption excluding out-of-pocket spending is less than the poverty line (World Health Organization, 2017). Both a headcount measure and 'poverty gap' measure were calculated. In the case of a household impoverished by out-of-pocket spending, the change in the gap is the amount by which out-of-pocket spending pushes the household below the poverty line. In the case of an already poor household, the change in the poverty gap is equal to the full amount of the household's out-of-pocket payments. These amounts are then averaged across all households to get the overall average change in the poverty gap due to out-of-pocket healthcare spending. In measuring impoverishing expenditure, a poverty line is required. In the 2017 WHO report, for global monitoring an international poverty line is used. However, it is noted that as countries and regions assess their own progress towards universal health coverage, they could also use relevant locally defined poverty lines (World Health Organization, 2017). A similar approach was used to track recent progress in achieving universal health coverage including an assessment of the impact of the COVID-19 pandemic (World Health Organization and World Bank, 2021).

### **2.4.3 The WHO Regional Office for Europe approach to assessing financial protection**

Identifying potential limitations with the measures of financial protection discussed above, especially for high income countries, the World Health Organization Regional Office for Europe has developed an updated approach to monitoring financial protection more relevant to high- and middle-income countries (Thomson et al., 2016). The new approach for European countries differs to that above along a number of domains, including:

- First, the method developed to measure catastrophic out-of-pocket payments builds on the 'capacity to pay' approach. It deducts consistently for all households a standard amount representing spending on three basic needs: food, housing (rent) and utilities. The standard amount is referred to as a basic needs or poverty line. With this approach, the incidence of catastrophic expenditure is more likely to be concentrated among the poor than with the budget share approach or with other capacity to pay approaches.
- Second, households are classified according to their risk of being impoverished after out-of-pocket payments using the basic needs line.

The European Region is working with national experts to produce in-depth, context-specific analysis of financial protection over time to enhance policy relevance at country level.

In 2019, the WHO Regional Office for Europe published a report examining financial protection in 24 high and middle-income countries (Thomson et al., 2019). The authors note that while financial protection indicators capture financial hardship arising from the use of healthcare services, they do not indicate whether out-of-pocket payments create a barrier to access, resulting in unmet need. Consequently, the report included estimates of both financial hardship and unmet need. In addition, the report incorporated consideration of equity by considering the distribution of catastrophic expenditure and unmet needs.

#### **2.4.4 Alternative frameworks for measuring universal healthcare**

A number of countries have developed specific frameworks for measuring progress to universal healthcare within their own jurisdiction. A special edition of the journal *PLOS Medicine* in 2014 on universal healthcare included a number of country-specific articles on monitoring and evaluating progress towards universal health coverage (Barreto et al., 2014; Meng and Xu, 2014; Nyonator et al., 2014; Tangcharoensathien et al., 2014). Similar to the WHO/World Bank framework for measuring universal health coverage, most of the country-specific analyses primarily focus on service coverage and financial protection. However, there were differences in services included and the methods used to measure financial protection. For example, in the analysis for China, service coverage included both health and non-health sector indicators (including safe drinking water) (Meng and Xu, 2014); while in a number of countries there was consideration of the social determinants of health and health outcomes (Barreto et al., 2014; Devadasan et al., 2014; Lai et al., 2014), highlighting the potential for more sophisticated analysis when a country specific assessment is adopted.

## **2.5 SUMMARY**

This chapter identified and discussed a number of considerations in relation to universal healthcare including the definition or meaning of universal healthcare and different approaches to its measurement. While there is no one definition of universal healthcare, there is also no one method of achieving universal healthcare. In the next chapter, different approaches to achieving universal healthcare will be examined.

## CHAPTER 3

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### Approaches to universal healthcare

#### 3.1 INTRODUCTION

While many countries are regarded as having a universal healthcare system, each of these systems differs along a number of domains including the services provided/ delivered, how healthcare is financed, and how healthcare providers are reimbursed. This section examines different approaches to universal healthcare. In particular, the chapter focuses on the extent of universal healthcare and how healthcare is financed, as these issues are of particular interest in the Irish context.

#### 3.2 EXTENT OF UNIVERSAL HEALTHCARE – WHO IS COVERED, FOR WHAT AND TO WHAT EXTENT?

The Universal Coverage Cube encompasses three dimensions – the extent of the population that is entitled to services paid from pooled funds, inclusion or exclusion of specific services from coverage, and the cost incurred to obtain these services (World Health Organization, 2010). This section reviews some of the available evidence on who is covered, for what and to what extent, in various countries with universal healthcare.

##### 3.2.1 Who is covered?

The basis for entitlement to healthcare services differs across universal healthcare systems. In some countries, entitlement is based on residency, in others on citizenship and in others on employment status or contributions. In addition, other factors such as age and health status may also influence entitlement. In some cases, entitlement is associated with the financing mechanism within a country. Tax financed systems are more likely to link entitlement to citizenship/residency, and social insurance systems are more likely to link entitlements to contributions. In many countries with universal healthcare systems, some groups are not entitled to healthcare services including illegal or undocumented migrants. These groups face particular barriers to accessing healthcare, as they often have limited access to informal social networks and safety nets, encounter legal barriers to care provision, and are regularly excluded from health insurance schemes and hence have to pay out-of-pocket for healthcare services (Onarheim et al., 2018).

Gaps in population coverage occur in countries that base entitlement on employment status or payment of contributions *and* lack effective mechanisms to enforce the collection of contributions from those required to pay them such as in Poland and Estonia (Thomson et al., 2019). Some countries that base entitlement on employment or payment of contributions have introduced a range of strategies

to ensure that coverage is close to universal – for example, exempting pensioners from having to contribute. In France the basis for entitlement has changed from employment to residence due to concerns about the growing number of young people not entitled to health insurance due to rising unemployment and other factors (Thomson et al., 2019). In Ireland, entitlement to some public healthcare services (including GPs) is based on income, age and to a lesser extent, health status. This has contributed to significant co-payments for primary care services (Kringos et al., 2013) and unmet healthcare needs (O’Reilly et al., 2007).

### 3.2.2 For what basket of services?

The basket of services or benefits package has been defined as:

*the set of services that is defined and regulated by the government and/or paid from the pooled funds either by the government or by another healthcare purchaser on behalf of covered individuals (Gotsadze and Gaal, 2010, p.188).*

Universal healthcare does not mean coverage for everything; rather each country moving towards universal healthcare must decide what services will be included in the benefits package. Consequently, countries vary in terms of what is covered. For example, while most high-income countries include primary and hospital inpatient care, there is less consistency about the inclusion of, for example, pharmaceuticals, dental services and social care.

Countries also differ in terms of how explicit the definition of the basket is as well as how decisions are reached about what services should be included. Schreyogg et al. (2005) reviewing the healthcare benefit basket in nine European countries in 2005 noted that there was a clear trend among the countries studied towards a more explicit definition of the benefit baskets. Countries, for example, which had recently introduced new healthcare legislation, such as Italy, Poland and Spain, had more explicitly defined benefit catalogues, while other countries with older healthcare legislation, for example, the UK’s English NHS Foundation Act (1946) and Germany’s Social Code Book (1988) had rather implicitly defined benefit catalogues, but increasingly work with negative lists (e.g. rather than listing included services, services that are not included are explicitly listed), based on evidence provided by independent institutions such as the English NICE and the German Institute for Quality and Efficiency (Schreyogg et al., 2005). The authors note that when there is an explicitly defined basket of services, there is a requirement for clear and transparent decision criteria for the inclusion and exclusion of benefits. While cost-effectiveness analysis is often mentioned as an important decision criterion; in reality the decision-making process is often guided by lobbying activities of certain actors in the system (Schreyogg et al., 2005). In contrast to this, countries with rather implicitly defined baskets such as England



and Germany define very transparent criteria for benefit exclusion, although lists with excluded services are minor compared to explicitly orientated countries. In addition, criteria such as cost effectiveness and even effectiveness are often restricted to one or a few sectors of the healthcare system, for example pharmaceutical or medical devices, and are not generalisable to all products or services (Schreyogg et al., 2005). Just because services are included in the benefits package does not mean they are available to people, available in a timely way or of sufficient quality to be effective (Thomson et al., 2019). Shortcomings in the availability, quality and timeliness of publicly financed healthcare services may result in unmet need but can also lead to an increase in out-of-pocket payments (Thomson et al., 2019).

Research has shown that the exclusion of particular services (in particular pharmaceuticals and dental services) from the basket of services can result in financial hardship and unmet need (Thomson et al., 2019). Out-of-pocket spending on medicines was found to be the main driver of financial hardship among people using healthcare services across a number of European countries (Thomson et al., 2019), while a lack of dental care coverage leads to financial hardship for richer households who can afford to pay out-of-pocket, and to unmet need for poorer households (Thomson et al., 2019).

### **3.2.3 To what extent? (Cost sharing)**

Patient cost-sharing refers to any direct payment made by healthcare service users to providers (Kutzin, 1998). There are three main forms: deductible – the amount that must be paid out-of-pocket before an insurer will pay out; co-payment – a flat amount that the beneficiary must pay for each service used; and co-insurance – the percentage of the total charge for a service that must be paid by the beneficiary.

In healthcare systems where individuals do not pay the full cost associated with the healthcare services they consume, cost-sharing is usually used to reduce demand for healthcare services in order to control costs. The magnitude of this effect depends on the price elasticity of demand, defined as responsiveness of the quantity demanded to a change in price. If cost-sharing is levied on services for which demand is largely price inelastic, co-payment shifts the burden of financing from the public sector to the users rather than lowering use. If cost-sharing is used on services for which demand is price elastic, co-payment may reduce the demand, thereby potentially also lowering total healthcare costs (Kiil and Houlberg, 2014). In some countries a second aim of cost-sharing is to raise revenue. Cost-sharing is used to some extent by almost all European countries for publicly provided healthcare services. It is most commonly applied to prescription drugs and dental care, but also to primary and inpatient care (Thomson et al., 2019).

A large body of research has considered the impact of user charges on healthcare services usage. One of the most influential studies in this area was the RAND health insurance experiment (HIE) in the US which sought to examine how cost-sharing affects the use of healthcare services (Keeler, 1992). The study ran from 1974 to 1977 and included 5,809 people who were randomly assigned into insurance plans that either had no cost-sharing, or 25, 50 or 95 per cent co-insurance (with a maximum annual family out-of-pocket payment of \$1,000). Overall, the experiment found that co-insurance reduced the use of all types of healthcare services. The average price elasticity was calculated to be -0.20 across the different types of healthcare services included in the experiment (Manning et al., 1987). Further analysis within the RAND HIE showed that co-insurance reduced the demand for effective and ineffective treatments to the same extent (Shapiro et al., 1986) and reduced the demand for healthcare services more for low-income groups, and in particular low-income children (Lohr et al., 1986). The impact of cost-sharing on health was ambiguous; cost-sharing was found to be associated with poorer blood pressure control, corrected vision and oral health but did not appear to have an impact on other aspects of health (Keeler, 1992). Since the RAND HIE, a number of other studies have examined the impact of cost-sharing on healthcare service usage. Reviewing the evidence across a range of healthcare services and countries, Kiil and Houlberg (2014) found that for all types of healthcare services except hospitalisations, the majority of reviewed studies found a negative effect of co-payments; the estimated price elasticities were all negative and less than one, implying that the individual demand drops by less than 1 per cent following a 1 per cent increase in the price paid by the consumer. The lack of an effect of cost-sharing on hospitalisations implies that co-payments for this type of treatment mainly shift the burden of financing from the public sector to the user rather than reducing demand (Kiil and Houlberg, 2014). There is convincing evidence that vulnerable groups reduce their use of healthcare services relatively more than the remaining population as a result of co-payments (Kiil and Houlberg, 2014). For example, despite healthcare need being greater in lower socio-economic groups, analysis from France, Germany and Spain found that in France, where patients share the cost of physician visits, people belonging to a low social class had fewer physician visits than those belonging to a high social class. Conversely, in Germany and Spain, where there is no cost-sharing for physician visits, people from lower socio-economic groups were more likely to visit the physician (Lostao et al., 2007).

There has been relatively little work done empirically examining the impact of removing or reducing (or increasing) user charges on total healthcare expenditure; however, the impact on expenditure will largely depend on the impact on the demand for services (as discussed above). Increased cost-sharing has the potential to slow the growth of healthcare spending if: there is a reduction in use of low-value or medically unnecessary care; any utilisation reduction is not offset by the use of more expensive services; and reductions in service use do not

result in adverse outcomes that may be more expensive to treat (Swartz, 2010). Contrary to the RAND study discussed above, a more recent American study found that increasing user charges for physician visits and prescriptions leads to an increase in total healthcare expenditure due to offset effects (Chandra et al., 2010); e.g. a reduction in the demand for physician visits and prescriptions may have contributed to a delay in seeking care and an associated increase in hospitalisations.

### **3.3 FINANCING UNIVERSAL HEALTHCARE**

While the Irish healthcare system is predominately financed through general taxation revenues, previous reform proposals in relation to universal healthcare recommended that some services should be financed through a system of universal health insurance. This section examines different approaches to financing universal healthcare and some of the implications of these different financing mechanisms.

#### **3.3.1 Financing healthcare**

There are four main approaches to financing healthcare systems in high income countries – taxation (government financed), social insurance, voluntary health insurance and out-of-pocket expenses – with most countries adopting a combination of methods. General taxation revenues are used as a source of financing to some extent in all high-income countries. Under a general taxation system, everyone who pays taxes contributes to financing healthcare. Depending on the degree of universality, the entire population or segments of the population have access to publicly provided healthcare services (Gottret and Schieber, 2006). General revenues tend to be considered the most equitable way to finance healthcare (Wagstaff et al., 1992), although the degree of equity will depend on the progressivity of a country's tax system (Chinitz et al., 1998). Advantages of using general revenues to finance healthcare include a large scope for raising resources and potential for administrative efficiency and cost control; however, the adequacy of funding may be dependent on the outcome of annual budget discussions (Gottret and Schieber, 2006).

Social insurance systems are in place in many Western European countries including Belgium, France, Germany, Austria and Luxembourg; while in Central and Eastern Europe and Central Asia, social insurance has emerged as the dominant financing model since the 1990s. There are two central common characteristics of social insurance funded systems (Normand and Busse, 2002). First, insured people pay a regular, usually wage-based, contribution. Second, independent quasi-public bodies (usually called sickness funds) act as the major managing bodies of the system and as payers for healthcare. Otherwise, social insurance systems differ along a number of dimensions including the number and size of health funds, the

system of risk equalisation, premiums, ceilings on contributions and the financing of vulnerable groups.

The size and role of PHI differ from country to country and can be classified as substitutive, supplementary or complementary (Mossialos and Dixon, 2002). Substitutive insurance is generally available to sections of the population who are excluded or choose to be excluded from the public system. For example, substitutive PHI is available in Germany for people whose earnings are above a certain threshold and who choose to leave the public system. Supplementary health insurance may allow quicker access to services (also covered by the public system), increase the quality of non-healthcare facilities (accommodation) and/or provide access to a greater number or choice of provider. Supplementary insurance is in use in several countries with tax-financed healthcare systems including Ireland and the UK. Finally, complementary health insurance offers full or partial cover for services that are not covered under the public healthcare system, and is common in many social insurance-based systems including France.

Out-of-pocket payments apply to some extent in all healthcare systems and involve people paying for healthcare services at the point of use. Here there is no pooling of risk but rather services are paid for when required. In most instances, out-of-pocket payments are the most regressive form of financing for healthcare because such payments constitute a much greater share of income for the sick and poor than for those who are healthy and better off (Chinitz et al., 1998). Many healthcare systems provide some degree of financial protection against out-of-pocket expenditure. In England, for example, while there is a co-payment for outpatient prescription drugs, many people are exempt on the basis of age, income and medical criteria.

### **3.3.2 Impact of different approaches to financing healthcare**

#### ***Tax versus social insurance***

A small body of research has examined how tax and social insurance financed systems differ in terms of the progressivity of the financing system, healthcare expenditure and health outcomes. Wagstaff et al. (1992), examining the progressivity or otherwise of healthcare financing systems, found that in general taxes are a progressive means of raising revenue with the overall degree of progressivity depending on the progressivity of each tax and the precise mix used. Conversely, social insurance was found to be a regressive method of raising healthcare revenue, typically because contributions are subject to a ceiling (this is not the case in Ireland), though in some countries the marginal contribution rates themselves decline as earnings rise (Wagstaff et al., 1992). The authors do note however that there are some progressive elements to social insurance, for example, certain groups such as pensioners are typically exempt from

contributions (Wagstaff et al., 1992) (although in Ireland the main beneficiaries tend to be higher-income retirees).

Examining the relationship between healthcare expenditure and financing system, Wagstaff used data from 29 OECD countries to determine whether having a social insurance system rather than a tax-financed system resulted in higher or lower healthcare expenditure per capita and whether having one system or the other results in better or worse outcomes with regard to amenable mortality (Wagstaff, 2009). He found that social insurance was associated with higher healthcare expenditure; in addition, there was no evidence that social insurance systems achieve lower rates of amenable mortality (Wagstaff, 2009). In fact, the evidence suggested in regard to premature mortality from breast cancer among women, that social insurance systems performed worse with 5-6 per cent more potential years of life lost. The author speculated that this may be due to the focus on individual members within social insurance systems, compared to tax-financed systems which may focus more broadly on the entire population and as a result public healthcare programmes, including screening, may be better organised and integrated within a tax-financed system.

While it appears that countries with social insurance systems tend to spend more than countries that finance healthcare through general taxation, Wagstaff (2009) has cautioned against concluding that the financing system is the cause of the additional expenditure in the social insurance systems. He suggests that whether a country has an insurance or a tax-financed system is likely to be endogenous, that is unobservable factors correlated with the outcome of interest (including expenditure) are also likely to be correlated with the choice of system. It might be that people are more willing to pay social health insurance contributions than tax because social health insurance revenues are earmarked for healthcare services and contributions confer entitlements to use them (Wagstaff and Moreno-Serra, 2009). In addition, if social insurance-based systems have a higher level of expenditure than tax-financed systems it is not clear whether this is due to the system itself (for example, due to the collection of contributions through a specific fund rather than through the general taxation system) or due to features or characteristics more generally associated with social insurance (such as a payment mechanism based on fee-for service) but not essential components of such systems.

### ***Private health insurance financing in a universal healthcare system***

While PHI is (to a greater or lesser extent) a means of financing healthcare in a number of countries, it can give rise to a number of concerns (Sagan and Thomson, 2016) including:

- inequitable (two-tier) access to healthcare services due to PHI coverage being

linked to higher socioeconomic status and provider incentives to prioritise the delivery of care to privately financed patients;

- the challenge of ensuring affordable access to PHI for some groups of people, especially those who are older, disabled or suffer from chronic conditions;
- high administrative costs among insurers;
- transaction costs associated with monitoring, regulation, improving access and affordability and legal challenges associated with PHI.

Reviewing PHI markets in Europe, Thomson and Mossialos (2009) examined the implications of private health insurance markets on a number of healthcare system goals including financial protection, access and efficiency, as well as exploring the ability of PHI to relieve pressure on public budgets.

### ***Financial protection***

PHI can provide financial protection for those who buy it by reducing their out-of-pocket expenditure on healthcare (Thomson et al., 2020). However, this is somewhat dependent on the role played by PHI. PHI can contribute to financial protection when it plays a substitutive role, since substitutive cover is an individual's only source of cover (Thomson and Mossialos, 2009). Supplementary PHI does not, in the main, provide financial protection since the people it covers are entitled to publicly-financed healthcare, the services it covers are usually already covered by the public healthcare system and the benefits it provides therefore relate to speed of access and quality of amenities (Thomson and Mossialos, 2009).

### ***Access***

Thomson and Mossialos (2009) identify two dimensions of access that might be influenced by PHI – the use of healthcare services and waiting times. Examining the potential role of PHI in accessing services across 21 OECD countries, van Doorslaer et al. (2006) found that after controlling for need, higher income groups were much more likely to see a specialist than lower income groups and the gradients appeared to be particularly large in Portugal, Finland, Ireland and Italy – four countries where private insurance and direct private payments play some role in accessing specialist services. Another study from Australia found that higher income Australians are more likely to consult a specialist, all else equal, while lower income patients are more likely to consult a GP (van Doorslaer et al., 2008). The authors argued that the unequal distribution of PHI coverage by income contributes to this finding. Looking at screening services, research from healthcare systems in which access to services relates to possession of PHI have found that the possession of PHI is one of the main determinants of cancer screening

utilisation (Weber et al., 2008; Swan et al., 2010). In Ireland, where screening services are publicly funded, PHI has been shown to be associated with the uptake of a range of screening services (Walsh et al., 2012; Connolly and Whyte, 2019) despite providing little advantage in accessing such services.

In terms of the relationship between PHI and waiting times, Tuohy et al. (2004) identify two competing hypotheses as to the association between the existence of a parallel private system and waiting times in the public sector. The first hypothesis is that there may be a negative correlation between the prevalence of a parallel private system and waiting lists for publicly provided services as the private alternative would reduce demand for publicly insured services. Conversely there may be a positive correlation for a number of reasons. These include:

- providers are drawn to the private system from the public system to the extent that the former is more lucrative, thus reducing the supply of publicly financed services;
- providers have an incentive to maintain lengthy waits for publicly financed services in order to increase demand for privately financed services or;
- the privately-financed services also require the provision of some publicly-financed services, such as back-up services to deal with complications and hence consume resources in the publicly-financed sector (Tuohy et al., 2004).

There is now a growing body of evidence showing shorter waiting times for people with PHI relative to those using the public system (Thomson and Mossialos, 2009). In Germany in the hospital sector the treatment of PHI holders can generate additional income through, for example, private rooms and costlier treatments (Kuchinke et al., 2009). As a result, hospitals may prioritise PHI patients. Using an experimental design Kuchinke et al. (2009) found that average waiting times for hospital care differed by insurance status, with PHI holders having shorter waits than SHI holders. While waiting times for both groups are relatively short, only 28 per cent of SHI-holders get an appointment within one week, compared to 41 per cent of private insurees. In the ambulatory sector, payments for treating PHI patients are about 20-35 per cent higher than for SHI patients. Lungen et al. (2008) examined waiting times for elective treatments for PHI and SHI patients and found that on average waiting times were 3.08 times longer for SHI patients compared to PHI patients. In Ireland, recent research has shown that, despite the proposed introduction of a common waiting list for public and private patients, those with PHI had a significant probability of shorter waits for both outpatient appointments and inpatient admission than those without PHI, even after controlling for a range of other possible covariates (Whyte et al., 2020). The authors noted that the cause of long waits for public hospital services in Ireland are likely to be multi-faceted and involve a complex interaction between the

demand for and supply of healthcare services. However, they questioned the role of PHI and the private provision of healthcare services within the system where a majority of public hospital consultants have a contract, which permits them to conduct private practice in public hospitals, and both consultants and hospitals are somewhat incentivised to treat private patients. For example, while hospital consultants are paid by salary for their public work, they receive fee-for-service for treating private patients (Brick et al., 2012); in addition, public hospitals are paid for treating admitted public patients on the basis of the amount of activity, with adjustments for the complexity of cases (Health Service Executive, 2015), and paid by insurers on a per diem basis for private patients (Turner, 2015). An important point to note however is that the observed differential in waiting times between private and public associated with PHI is not an inevitable feature of the PHI market; it is more to do with government reluctance to address apparently perverse incentives in the wider healthcare system, and in some cases government willingness to facilitate these through tax subsidies for PHI (Thomson and Mossialos, 2009).

### *Efficiency*

Generally, a feature of PHI markets is competing, for-profit insurers (often introduced to enhance efficiency (Thomson et al., 2013)); however, such competing providers may be more cost inflationary as marketing expenses, the need to generate profit and costs associated with regulation can drive up cost. Mathauer and Nicolle (2011) examining administrative costs for social security and PHI schemes across high income OECD countries found that, on average, PHI administrative costs were three times higher than those of social security schemes. They note that while the rationale for competition is increased efficiency (assuming administrative costs would decrease because competition would force insurers to be more efficient in their insurance management), the level of competition is often limited so that the anticipated effect is not observed in practice. Comparing healthcare administration costs in the US and Canada, Woolhandler et al. (2003) found that in 1999, healthcare administration costs were \$1,059 per capita in the US and \$307 per capita in Canada, accounting for 31 per cent and 17 per cent of healthcare expenditure respectively. They argue that several factors increase administrative costs in the US including the larger role of private insurers in the US with their higher overhead costs.

Other factors too can contribute to increased cost of private health insurance financing. Previous research for Ireland examined the potential cost of universal healthcare in Ireland financed through competing health insurers (Wren et al., 2015). The authors found that total healthcare expenditure could increase by between 3.5 and 10.7 per cent under the proposed scheme, with the 'insurers margin' the greatest contributor to additional healthcare costs. Here, the insurers margin was defined as the margin between insurers' earned premium income and their expenditure on claims incurred, and comprises expenses and the cost of



reinsurance, and underwriting profit or loss, plus the impact of investments, which sum to profit before tax.

### ***Relieving pressure on public budgets***

One of the arguments sometimes put forward in favour of a PHI market is that it may relieve pressure on public budgets by shifting expenditure for some healthcare services to private insurers (Thomson and Mossialos, 2009). Substitutive PHI may help to ensure that limited public funds are spent mainly on poorer people, leaving richer people to look after their own healthcare needs (Thomson and Mossialos, 2009). However, there are a number of potential problems with this argument including issues of risk segmentation and lack of solidarity. If the more affluent opt-out of the public system, given the positive association between socio-economic and health status, the remaining pool within the public system are likely to be high risk, thereby potentially requiring regulation to compensate the public system for covering a disproportionate number of high risk individuals (Thomson and Mossialos, 2009). In the Netherlands (prior to the 2006 reforms), for example, the Government introduced a levy for those with PHI to compensate the public scheme for including a large number of older people (Thomson et al., 2020). Solidarity may also be an issue with those participating in the substitutive PHI market not wishing to pay taxes towards a healthcare system that they will not use.

Thomson and Mossialos (2009) argue that in theory complementary PHI could relieve pressure on public budgets by enabling the publicly financed system to pay for a minimum level of benefits focusing on necessary and cost-effective services, which creates a role for complementary cover of services excluded from the publicly financed benefits package. However, they argue that this rarely happens in practice, and it is usually services that are less politically visible (such as eye and dental care) that are excluded from public system.

It is very unlikely that supplementary PHI might relieve pressure on the public healthcare system (Thomson and Mossialos, 2009). In Ireland for example, the evidence suggests, historically at least, that public budgets actually provide a subsidy to the PHI market through factors such as tax relief on premiums and not charging the full economic cost of privately insured care delivered in public hospitals (Turner, 2009); however this is now being addressed (Turner and Smith, 2020).

## **3.4 SUMMARY**

This chapter has highlighted that there is no one approach to achieving a universal healthcare system. However different approaches come with different strengths and limitations. In the next chapter, potential lessons for Ireland in achieving a universal healthcare system will be identified and discussed.

## CHAPTER 4

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### Lessons for Ireland

#### 4.1 INTRODUCTION

The preceding chapters have identified and discussed a number of important considerations in relation to universal healthcare. This chapter discusses some recent developments in healthcare policy in Ireland in relation to universal healthcare and identifies some lessons for Ireland in moving towards a universal healthcare system.

#### 4.2 TOWARDS UNIVERSAL HEALTHCARE IN IRELAND?

Notwithstanding the need for a definition of universal healthcare, there are a number of issues with the Irish healthcare system which potentially conflict with the idea of universal healthcare.

With regard to affordability of primary care services, previous research has shown that Ireland performs relatively poorly, having the highest formal co-payments for primary care among 31 European countries examined (Kringos et al., 2013), and there is a growing body of research finding that high out-of-pocket payments for GP services may be deterring people from visiting the GP. For example, asking about cost as a deterrent from attending the doctor, O'Reilly et al. (2007) found that in the Republic of Ireland almost 19 per cent of patients (4 per cent of non-paying patients and 26 per cent of paying patients) had a medical problem in the previous year but had not consulted the doctor because of cost; this compares to only 1.8 per cent of patients in Northern Ireland (where GP services are available free at the point of use). Among paying patients, it was the poorest and those with the worst health who were more affected. In later analysis, Connolly and Wren (2017) found that of those reporting an unmet healthcare need in Ireland, 59 per cent attributed their unmet need to affordability issues. Affordability issues were most common among those without a Medical/GP visit card suggesting that they may be related to the high cost of accessing GP and other primary care services for those who pay at the point of use. Murphy et al. (2016) found that those without a Medical Card were less likely to be in receipt of treatment for their hypertension than those with a Medical Card, while McHugh et al. (2015) found that those required to pay a fee for the flu vaccination were less likely to receive it than those not required to pay a fee.

Long delays in receiving care are also an issue within the Irish healthcare system. In relation to publicly financed hospital services, Brick and Connolly (2021) found that, in 2018, Ireland performed poorly relative to other European countries in

terms of waiting times for a range of procedures including hip and knee replacements. Since then, the COVID-19 pandemic and associated restrictions on healthcare activity has contributed to an increase in waiting times for hospital services so that, by mid-2021, 41 per cent of those on a public waiting list for an outpatient appointment had been waiting more than 12 months (Connolly et al., 2022). Whyte et al. (2020) found that those without private health insurance (PHI) were significantly more likely to be waiting for hospital treatment for more than three months relative to those with PHI. Delays in accessing public hospital services have contributed to a large proportion of the population purchasing PHI. While PHI coverage can facilitate quicker access to hospital services, recent analysis for Ireland found that payments for PHI were a significant contributor to unaffordable spending for poorer households (Johnston et al., 2019).

There are also significant delays to access many publicly provided community-based services, with a recent report noting that in December 2020 there were almost 40,000 clients waiting for an occupational therapy appointment, 50,000 awaiting a physiotherapy appointment and 12,000 awaiting a psychology appointment (Walsh et al., 2021). The numbers on the waiting list and the proportion waiting more than 12 weeks have been increasing over time and this has been further exacerbated by the COVID-19 pandemic, particularly in mid-2020 (Walsh et al., 2021).

Further, a lack of availability of some services in particular areas of the country can also act as a barrier to accessing required healthcare services. While waiting list numbers show the number of people that have been referred for a particular service, the actual number needing particular services is likely to be greater, as some people may not be referred for a service if the service is not available within their particular area or if the waits are very long (Walsh et al., 2021). Smith et al. (2019), for example, previously highlighted significant inequalities in the supply of primary, community and long-term care services across counties in Ireland, inequalities which were maintained after adjustment for need factors including age, health and Medical Card rates.

Recognising the need to reform the Irish healthcare system, in 2011 the Government committed to a universal healthcare system:

*designed according to the European principle of social solidarity: access will be according to need and payment will be according to ability to pay*  
(Department of the Taoiseach, 2011).

The 2011 Programme for Government proposed to end the public/private differential in accessing hospital care and to introduce GP care which is free at the

point of use for all in a system financed by universal health insurance (UHI). A 2014 White Paper elaborated on these details noting that UHI would finance aspects of primary and hospital care, whereas programmes such as long-term and community care would remain tax and out-of-pocket financed (Department of Health, 2014). Every member of the population would be insured for the same package of healthcare services, with individuals purchasing insurance for this standard package from one of a number of competing health insurers. Financial support would be available to ensure affordability by directly paying or subsidising from taxation the cost of insurance premiums for people on lower incomes. The 2014 White Paper provided little detail on the potential cost implications of the proposed reforms; however, a report published in 2015 estimated that the proposed model of UHI would increase healthcare expenditure in Ireland by between 3.5 and 10.7 per cent (Wren et al., 2015). Following publication of the costing analysis, the Minister for Health announced that:

*the high costs for the particular model of health insurance ... are not acceptable, either now or any time in the future* (Department of Health, 2015).

Subsequently this model of UHI disappeared from the political agenda.

Following a general election in 2016, an all-party parliamentary committee (Committee on the Future of Healthcare) was established with the aim of achieving a single long-term vision for healthcare and the direction of healthcare policy in Ireland. The Committee's final report (Sláintecare) concluded that:

*the health care system must be re-orientated to ensure equitable access to a universal single tier system, and that the vast majority of care takes place in the primary and social care settings* (Houses of the Oireachtas Committee on the Future of Healthcare, 2017).

The report recommended the introduction of universal GP and primary care, ending private practice in public hospitals, reducing or removing out-of-pocket fees and substantially increasing public healthcare expenditure and capacity in a tax-funded system. Some progress has been made in implementing the proposals identified in the Sláintecare report (Government of Ireland, 2022); however, progress in improving access to healthcare has been relatively slow (Thomas et al., 2021). While inpatient charges for public hospital services have been abolished, it remains to be seen if measures to reduce user charges for primary care services and to tackle long waits for a variety of services will be implemented and will have an impact on the current barriers to accessing healthcare services in Ireland.

### 4.3 MOVING TOWARDS UHC IN IRELAND – SOME CONSIDERATIONS

This section identifies and discusses three lessons for Ireland in moving towards universal healthcare.

#### 4.3.1 As a starting point a definition of universal healthcare is required

As discussed in Section 2.2, there is no one definition of universal healthcare. In practice, it is necessary to identify and make explicit the definition or interpretation of universal healthcare which is being adopted within a particular context. An explicit definition will provide a starting point for thinking about what a universal healthcare system will look like in practice and will help identify appropriate metrics for its measurement.

Within the Sláintecare report there is ambiguity about what definition of universal healthcare is implied and about what a universal healthcare system in Ireland might look like in practice (Houses of the Oireachtas Committee on the Future of Healthcare, 2017). For example, the report is unclear on whether its definition of universality implies access to care that is free at the point of use. While the report recommends universal GP and primary care explicitly referencing progressive extension of entitlement to free GP care, it is not clear whether the Committee envisaged that charges should remain for access to other primary and social care services.

A key distinction between the WHO and EU interpretation of universality is that the WHO version focuses on the avoidance of financial hardship:

*to ensure that every individual and community, irrespective of their circumstances, should receive the health services they need without risking financial hardship (World Health Organization and World Bank, 2017);*

while the EU version focuses on access:

*Universality means that no-one is barred access to health care; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need regardless of ethnicity, gender, age, social status or ability to pay (Council of the European Union, 2006).*

For a number of reasons, in the Irish context, it could be argued that the EU definition is the more appropriate. First, the WHO definition (with its emphasis on financial hardship) is very difficult to differentiate from the current Irish means-tested system. While the current system provides a safety net for the poorest members of society, there is no universal entitlement to a range of primary care

services for a majority of the population (OECD and European Observatory on Health Systems and Policies, 2019; Johnston et al., 2020). Second, the WHO interpretation of universality would not encompass situations where people were unable to access healthcare due to very long waits or where people forego healthcare due to high user charges (e.g. people not attending the GP due to cost). Third, the WHO definition appears designed for low and middle-income countries; since Ireland is an EU Member State, the EU definition appears more relevant.

Clarity is required on the definition and interpretation of universal healthcare in the Irish context. Only then will it be possible, first, to determine if there is political consensus on achieving universal healthcare and, second, to appropriately cost the proposals and identify if there a commitment to funding universal healthcare (Connolly and Wren, 2019).

#### **4.3.2 There are different dimensions to universal healthcare**

If the EU definition of universal healthcare is accepted as the appropriate one in the Irish context, then there is a need to move beyond a limited focus on financial barriers to accessing healthcare towards considering other factors which also impact on access. While there is an entitlement to a range of healthcare services in Ireland (including public hospital care with no or limited user charges), long waits for such services mean that in practice this entitlement is severely curtailed. In addition to addressing the financial barriers to accessing primary care services, there is an urgent need to reduce waiting times for a range of services.

No healthcare system achieves 100 per cent coverage of the total population for all potential healthcare services at no cost to users. When moving towards universal healthcare, there is likely to be a trade-off between increasing population coverage, service coverage or cost coverage. The implication for each of the areas (population, service and cost) should be considered when implementing policies which move towards universal healthcare. In addition, reform proposals such as universal GP care could improve cost coverage; however, if there are not a sufficient number of GPs to meet the additional demand that would arise from its introduction then the availability or timeliness of services may be negatively impacted (Connolly et al., 2023).

A further consideration relates to factors outside the healthcare system and how they might impact on achieving universal healthcare. While many universal systems are concerned with ensuring equal access for equal need, a universal system which provides healthcare free at the point of use will not necessarily provide equal access for equal need. For example, the location of services is important; while there may be an entitlement to a service, if an individual cannot

access that service due to location or transport issues then the entitlement is limited.

#### **4.3.3 There is no one way to achieve universal healthcare however careful consideration of the role of PHI in a universal healthcare system is required**

Achieving universal healthcare is not dependent on a particular healthcare system structure. Countries with universal healthcare differ in terms of their financing systems and system structures, and often include both public and private providers. However, a commonality between universal healthcare systems is that at the outset of their development, they shared and maintained a political commitment to universality. At present it is not clear if there is a widespread political commitment to universal healthcare in Ireland (Connolly and Wren, 2019). While the Sláintecare report was produced by a cross-party committee, progress in the implementation of the reforms outlined in the report, particularly around eligibility and access, has been limited.

A particular concern in the Irish context is the role of the PHI market in a universal healthcare system. While a proportion of healthcare is financed by PHI in many universal healthcare systems, what is unusual in Ireland is the size of the PHI market in terms of the proportion of the population covered by PHI and relatedly the degree of regulation. Previous research has shown that achieving universal healthcare through the extensive use of PHI can give rise to a number of potential issues including inequitable access to healthcare services, high administrative costs among insurers as well as costs associated with monitoring, regulation, improving access and affordability associated with PHI (Thomson et al., 2020).

A small body of research has explored the implications of PHI within the Irish healthcare system. Connolly and Whyte (2019), for example, found that the uptake of cancer screening in Ireland was significantly higher in those with PHI even after controlling for a range of confounders including health and socio-economic status, and highlighted the need to identify the reasons for the higher uptake, given that insurance does not confer any advantages in accessing these services. Murphy et al. (2020) found that those with PHI were more likely to have had an inpatient hospital stay than those without PHI, even after controlling for a range of potentially confounding variables including age group and health status. Whyte et al. (2020) found that a significantly higher proportion of those without PHI were waiting more than three months for hospital services relative to those with PHI, while analysis by Johnston et al. (2019) found the PHI premiums were the main contributor to unaffordable private healthcare spending in Ireland.

The Irish State has historically placed a strong emphasis on the role of private care, and consequently PHI, in the Irish system. Traditionally, private care was seen as a means to increase individual responsibility for healthcare thus alleviating pressure on the public system. Moreover, the mixed public/private model of hospital care was supported as a means of encouraging the retention of top medical specialists to the public system (Turner and Smith, 2020). As such, the State has historically pursued a policy of incentivising private care through public subsidisation (Turner, 2015), including private beds in public hospitals being charged below their true economic cost and tax relief on insurance premiums. Since 2014, some unwinding of this subsidisation has taken place (Turner, 2015).

One of the recommendations of the Sláintecare report was that an impact analysis should be carried out on the separation of private practice from the public hospital system, with a view to identifying any adverse and unintended consequences that may arise for the public system in the separation. The subsequent impact analysis concluded that private activity could be removed from public hospitals but that additional reforms would also be necessary, including the recruitment of a number of consultants to work within the public healthcare system (Independent review group, 2019). A new consultant's contract (which only allows consultants to treat public patients in public hospitals) has been agreed by Government and is in place for new consultants; however, it remains to be seen how many existing consultants will avail of the contract given strong opposition to some aspects of the contract (Dwyer, 2021). At the same time, the proportion of the population holding PHI has been increasing in recent years (Department of Health, 2022), perhaps related to the introduction of lifetime community rating regulations in 2015, which require that individuals aged 35 and older taking out health insurance for the first time pay an additional 'late-entry' penalty on their premium (Keegan, 2020). However, the increase in take-up can be seen across all age groups and is particularly large among those aged 80 and over (Department of Health, 2022).

The proposal of removing private practice from public hospitals, if successfully implemented, may generate some limited additional capacity within the public system (Independent review group, 2019; Keegan et al., 2022). However, if (as current proposals suggest), PHI can still be used to access privately financed services in private facilities, then access to some healthcare services will continue to be based on ability to pay rather than need. Consequently, there is an urgent need to identify what role there is for PHI in a universal healthcare system in Ireland where access to services is based on need rather than ability to pay.

#### **4.4 SUMMARY**

If there is to be a universal healthcare system in Ireland, then careful consideration around a number of issues is required. In the first instance, it is essential to identify



what is meant by universal healthcare and what a universal healthcare system in Ireland might look like in practice. This should include an assessment of the extent of user charges and the role of PHI in a universal healthcare system in Ireland. Only then will it be possible to determine if there is a political consensus on achieving universal healthcare (Connolly and Wren, 2019) and to define metrics to measure its achievement. The barriers to access to healthcare in Ireland discussed in this report suggest that a primary goal of universality in Ireland should be improving access and that measurable gains in this regard should be included in any metric for the measurement of universality.

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