The Path to Universal Healthcare
Preliminary Paper on Universal Health Insurance
## Contents

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>The Vision for our Health System</strong></td>
<td>3</td>
</tr>
<tr>
<td>1.1 <strong>Universal Health Insurance for Ireland</strong></td>
<td></td>
</tr>
<tr>
<td>1.2 <strong>Purpose and Guiding Principles</strong></td>
<td></td>
</tr>
<tr>
<td>1.3 <strong>Building Blocks for Universal Health Insurance</strong></td>
<td></td>
</tr>
<tr>
<td>1.4 <strong>Layout of Paper</strong></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Overview of Work Structures</strong></td>
<td>7</td>
</tr>
<tr>
<td>2.1 <strong>Implementation Group on Universal Health Insurance</strong></td>
<td></td>
</tr>
<tr>
<td>2.2 <strong>Universal Primary Care Project Team</strong></td>
<td></td>
</tr>
<tr>
<td>2.3 <strong>Programme Management Office for Health Reform</strong></td>
<td></td>
</tr>
<tr>
<td>2.4 <strong>Health Insurance Consultative Forum</strong></td>
<td></td>
</tr>
<tr>
<td>3. <strong>Primary Care</strong></td>
<td>9</td>
</tr>
<tr>
<td>3.1 <strong>Broad Description of the Workstream</strong></td>
<td></td>
</tr>
<tr>
<td>3.2 <strong>Guiding Objectives for the Workstream</strong></td>
<td></td>
</tr>
<tr>
<td>3.3 <strong>Progress to Date</strong></td>
<td></td>
</tr>
<tr>
<td>3.4 <strong>Next Steps</strong></td>
<td></td>
</tr>
<tr>
<td>4. <strong>Hospital Structures</strong></td>
<td>12</td>
</tr>
<tr>
<td>4.1 <strong>Broad Description of the Workstream</strong></td>
<td></td>
</tr>
<tr>
<td>4.2 <strong>Guiding Objectives for the Workstream</strong></td>
<td></td>
</tr>
<tr>
<td>4.3 <strong>Progress to Date</strong></td>
<td></td>
</tr>
<tr>
<td>4.4 <strong>Next Steps</strong></td>
<td></td>
</tr>
<tr>
<td>5. <strong>Hospital Financing</strong></td>
<td>15</td>
</tr>
<tr>
<td>5.1 <strong>Broad Description of the Workstream</strong></td>
<td></td>
</tr>
<tr>
<td>5.2 <strong>Guiding Objectives for the Workstream</strong></td>
<td></td>
</tr>
<tr>
<td>5.3 <strong>Progress to Date</strong></td>
<td></td>
</tr>
<tr>
<td>5.4 <strong>Next Steps</strong></td>
<td></td>
</tr>
<tr>
<td>6. <strong>Regulation of Healthcare Providers</strong></td>
<td>20</td>
</tr>
<tr>
<td>6.1 <strong>Broad Description of the Workstream</strong></td>
<td></td>
</tr>
<tr>
<td>6.2 <strong>Guiding Objectives for the Workstream</strong></td>
<td></td>
</tr>
<tr>
<td>6.3 <strong>Progress to Date</strong></td>
<td></td>
</tr>
<tr>
<td>6.4 <strong>Next Steps</strong></td>
<td></td>
</tr>
<tr>
<td>7. <strong>Health Insurance Market</strong></td>
<td>23</td>
</tr>
<tr>
<td>7.1 <strong>Broad Description of the Workstream</strong></td>
<td></td>
</tr>
<tr>
<td>7.2 <strong>Guiding Objectives for the Workstream</strong></td>
<td></td>
</tr>
<tr>
<td>7.3 <strong>Progress to Date</strong></td>
<td></td>
</tr>
<tr>
<td>7.4 <strong>Next Steps</strong></td>
<td></td>
</tr>
</tbody>
</table>
8. **Enabling Change**  
8.1 Introduction  
8.2 New Transitional Governance Structures  
8.3 Work of the Special Delivery Unit  
8.4 National Clinical Programmes  
8.5 Health Information and ICT  
8.6 Human Resources

9. **Designing a Universal Health Insurance Model for Ireland**  
9.1 Broad Description of the Workstream  
9.2 International Evidence

10. **Developing the White Paper**  
10.1 Development of an Analytical Framework and Capacity  
10.2 Policy Choices and Trade-offs
1. The Vision for our Health System

1.1 Universal Health Insurance for Ireland
The Government is committed to a single-tier health service, supported by universal health insurance, which provides equal access based on need, not ability to pay, and which delivers the best health outcomes for Irish citizens.

Under universal health insurance (UHI), everyone will be insured for a standard package of primary and hospital care services, including mental health services. Insurance will be provided under a multi-payer insurer model with no distinction between “public” and “private” patients. The system will be founded on principles of social solidarity, encompassing the fundamental tenets of financial protection, open enrolment, lifetime cover and community rating.

While health insurance will be mandatory, a system of financial support will ensure affordability by paying or subsidising the cost of insurance premia for all those who qualify.

The introduction of UHI will see the purchasing of healthcare largely devolved to insurers. Health insurers will commission care for their members from primary care providers, independent not-for-profit Hospital Trusts and private hospitals. In doing this, they will have a duty to use their purchasing role to ensure the provision of quality, continuous care across settings. Furthermore, in line with the fundamental principle of social solidarity, neither insurers nor providers operating within the UHI system will be allowed to sell faster access to services covered by the UHI standard package of care.

Finally, the future UHI landscape will include a number of important regulators and national statutory bodies including the Health Information and Quality Authority. These bodies will regulate the quality of all health and social care services and will ensure that providers exercise good governance, thereby guaranteeing their long-term viability and availability for the communities they serve. The health insurance market will also be subject to regulation. A new Insurance Fund will have a central strategic role in managing the flow of funds between different arms of the health system, directly financing and centrally controlling some healthcare costs, and working with health insurers to support the delivery of high quality, integrated care.

1.2 Purpose and Guiding Principles
At the heart of the Government’s plans on universal health insurance is a clear desire to improve our health system’s ability to achieve its core purpose. This purpose has been articulated in the Department’s Statement of Strategy 2011-2014 as being:
to keep people healthy;
to provide the healthcare people need;
to deliver high quality services; and

to get best value from health system resources.

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

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

In shaping the future UHI system for Ireland, it is vital that we create a model which meets the needs of the Irish system and the Irish people. While it is important to learn from other countries and international best practice, ultimately, this requires us to take account of our unique demographic, geographic, social, political and cultural landscape, and to tailor our national UHI system accordingly. We must build a model which acknowledges our starting point and which is grounded in a meaningful and clearly communicated value system. Thus, in addition to the vision statement outlined above, a number of core principles have been developed to underpin the design of the future system. These are as follows:

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

In implementing UHI, there are many important building blocks which must be put in place, including:

- the strengthening of primary care services to deliver universal primary care with the removal of cost as a barrier to access for patients;
- the work of the Special Delivery Unit in tackling waiting times and establishing Hospital Groups as a precursor to Hospital Trusts;
- the introduction of a more transparent and efficient "Money Follows the Patient" funding mechanism and a corresponding charging regime for private patients;
- the introduction of licensing legislation and a robust regulatory framework for healthcare providers; and
- reform of the private health insurance market.

Each of these building blocks can be arranged into a number of broad workstreams as outlined in figure 1 below. As that figure demonstrates, each of the workstreams must be informed and guided by overall health system objectives and all of them are dependent on a series of critical enabling factors and initiatives, including the introduction of a unique patient identifier, the development of supporting Information Technology and the flexibility provided by the Public Service (‘Croke Park’) Agreement.

**Figure 1: Workstreams under Universal Health Insurance**

To develop an efficient and effective single-tier health service which promotes the health and well-being of the population and which provides equitable access to high quality care on the basis of need.
1.4 Layout of this Paper

*Future Health: A Strategic Framework for Reform of the Health Service 2012-2015* sets out a strategic vision for reform of the health system and identifies the key high-level actions needed to systematically deliver on this challenging change agenda. Building on that strategic vision, the purpose of this preliminary paper is to provide a succinct update on work in relation to universal health insurance as well as providing further detail on the path ahead. The remainder of this paper is, therefore, as follows.

Chapter 2 briefly outlines the structures which have been put in place to support the health reform agenda. Chapters 3 to 7 consider each workstream under UHI in terms of mapping out the building blocks to be put in place, reviewing progress to date and setting out next steps. Chapter 8 briefly identifies and summarises progress in relation to several critical enablers. Finally, chapters 9 and 10 identify the major issues to be addressed in designing the future UHI model and developing the *White Paper on Universal Health Insurance*. 
2. Overview of Work Structures

As can be seen from section 1.3, the path to universal health insurance involves complex, ‘whole system’ reform which will have to be very carefully managed and sequenced on a step-by-step basis. In order to help the Department in this task, several key structures have been agreed. These structures comprise a mix of both advisory and consultative bodies (e.g. the UHI Implementation Group, Health Insurance Consultative Forum) and new executive entities (e.g. the Programme Management Office, Universal Primary Care Project Team). Details of the structures are set out below.

2.1 Implementation Group on Universal Health Insurance

In February 2012, the Minister for Health established the Implementation Group on Universal Health Insurance. The Group is tasked with assisting the Department in developing detailed and costed implementation proposals for universal health insurance and in driving the implementation of various elements of the reform programme. The Group will also advise the Department on drafting the White Paper on Universal Health Insurance.

The role of the Group is an expert advisory one. This is reflected in its composition which is not representative of all stakeholders, but, rather, consists of a mix of those with executive responsibilities within the health service and external expertise, including international experts, as follows:

- Dr. Fergal Lynch, Deputy Secretary General, Department of Health (Chair);
- Paul Barron, Assistant Secretary, Primary Care, Department of Health;
- Dr. John Barton, Physician/Cardiologist, Portiuncula Hospital;
- Prof. Reinhard Busse and Dr. Sarah Thomson (acting as alternates), international experts working with the World Health Organisation, the European Observatory on Health Systems and Policies and others;
- Dr. Martin Connor, Special Adviser to the Department of Health with international experience in healthcare management;
- Brian Fitzgerald, Interim CEO, St. James' Hospital;
- Tom Heffernan, Principal Officer, Department of Public Expenditure and Reform;
- Mark Moran, Former CEO of the Mater Private Hospital and former Chairman of the DoH/HSE Working Group on Reference Pricing and Generic Substitution;
- Dr. Fergus O’Ferrall, Lecturer in Health Policy, Trinity College Dublin;
- Dr. Barry White, Former National Director for Clinical Strategy and Programmes, HSE, and
- Liam Woods, National Director of Finance, HSE.

In line with the expert advisory focus of the Group, its membership will be subject to periodic review as different stages in the implementation process are reached.
The Implementation Group met on six occasions during 2012 and provided advice in relation to the Department’s policy work on ‘Money Follows the Patient’, Hospital Groups and overall design of the UHI model.

2.2 Universal Primary Care Project Team
In conjunction with the Implementation Group, the Government has established a Universal Primary Care Project Team, chaired by Paul Barron, Assistant Secretary, Department of Health, to drive reform of primary care. The projects being overseen by the Team include:

- Planning, costing and legislative preparation for the extension of free GP care;
- Development of chronic disease management in primary care;
- Promotion of capital investment in primary care centres;
- Preparation for a new GP Contract to facilitate universal free GP care and intensive chronic disease management;
- Development of a transparent, objective formula for resource allocation in primary care; and
- Preparation for new governance and funding arrangements for primary care.

2.3 Programme Management Office for Health Reform
The Department of Health is currently finalising plans for the establishment of a Programme Management Office (PMO) to drive, co-ordinate and monitor the health reform programme. The PMO will have a central, overarching, co-ordination function in relation to health reform, ensuring that a structured, service-wide approach is taken to implementation. It will also be responsible for taking a strategic view on the timetabling and sequencing of various reform work strands, and for communication, monitoring and control activities in respect of the overall programme.

The Department has produced an integrated reform plan for the health sector which will represent a key management tool for the PMO. The plan maps and sequences both sectoral and cross-cutting reform priorities for the health sector, identifying time bound targets and key deliverables for each priority issue. It encompasses the major timebound actions listed in Future Health: A Strategic Framework for Reform of the Health Service 2012-2015 and the revised Health Sector Action Plan for implementation of the Public Service Agreement, in addition to other more detailed tasks and projects. The Department reports into the Department of Public Expenditure and Reform on progress against the Integrated Reform Plan on a regular basis.

2.4 Health Insurance Consultative Forum
The UHI Implementation Group is complemented by a Health Insurance Consultative Forum which includes representatives from the country’s four commercial health insurance companies, the Health Insurance Authority and the Department of Health. The Forum is tasked with examining how costs in the health insurance sector can be reduced whilst always respecting the requirements of competition law. In addition, the Forum provides a vehicle for engagement on issues relating to the implementation of UHI.
3. Primary Care

3.1 Broad Description of the Workstream
The Programme for Government commits to significant strengthening of primary care services to achieve Universal Primary Care (UPC) with the removal of cost as a barrier to access for patients. The primary care workstream is, therefore, centrally concerned with delivering on the phased introduction of UPC over the lifetime of the Government. The first phase will provide for the extension of access to GP services without fees to persons with illnesses or disabilities to be prescribed under new legislation. Access to GP services will be subsequently extended on a phased basis with universal access to GP care without fees to be achieved in the final phase.

In order to deliver on this commitment, the preparation of a new General Medical Services (GMS) contract with GPs will be required. The new contract will have an increased emphasis on the management of chronic conditions, such as diabetes and cardiovascular conditions, with a focus on prevention and will include a requirement for GPs to provide care as part of integrated multidisciplinary primary care teams. Full implementation of UPC will also involve the development of a system of compulsory, universal registration with a primary care team.

Finally, the workstream also involves the development of physical and ICT infrastructure for primary care.

3.2 Guiding Objectives for the Workstream
The overall aim of initiatives under this workstream is:

- to strengthen access to, and affordability of, primary health care for the whole population;
- to deliver a new model of care which ensures provision of proactive, quality care in the most appropriate setting, thereby resulting in a more efficient and responsive healthcare system and improved patient outcomes; and
- to support the move towards a single-tier system where everyone is insured and has their care financed on the same basis.

3.3 Progress to Date
Creation of a Universal Primary Care Project Team
The Universal Primary Care Project Team was established in January 2012. It is tasked with working through the issues relating to the introduction of UPC, including driving progress across several distinct work areas as outlined below.
Extension of free GP care
Legislation to allow the Minister for Health to make regulations to extend access to GP services without fees to persons with prescribed illnesses is currently being drafted by the Attorney General’s Office and the Department of Health. Publication is expected shortly with implementation dates to be determined in due course.

Chronic Disease Management
The HSE is developing integrated chronic disease management programmes to improve patient access and care in an integrated manner across service settings, resulting in best health outcomes, enhanced clinical decision making and the most effective use of resources. Guidelines are being developed for the following priority programmes relevant to primary care: Stroke, Heart Failure, Asthma, Diabetes and COPD.

The Diabetes programme is due to start shortly. To this end, the Department has given approval to the HSE to recruit 17 Integrated Care Diabetes Nurse Specialists to support the phased roll out of the Diabetes Programme. Funding for these posts was confirmed in the HSE National Service Plan for 2013. Additional funding has also been provided to facilitate the implementation of the National Diabetic Retinopathy Screening Service in 2013 and to provide for Diabetic Retinopathy treatment.

Capital Investment in Primary Care Centres and ICT
Progress is also being made in relation to the development of primary care physical and ICT infrastructure. Primary care infrastructure is being delivered in three ways, namely via HSE direct build, a leasing initiative and a Public Private Partnership (PPP) initiative announced in July 2012.

The Capital Plan 2012-2016 contains provision for the delivery of primary care infrastructure at eight locations, while the leasing initiative is expected to deliver up to sixteen facilities which should be substantially completed by end 2013 / early 2014. The PPP initiative was developed in the context of the Government’s recent €2¼ billion Infrastructure Stimulus Package. It will see up to €115 million being made available for two bundles of primary care centres to be delivered by PPP.

Of the 35 PPP locations announced in July 2012, approximately 20 will be offered to the market subject to a) agreement between the local GPs and the HSE on active local GP involvement in the centres and b) site suitability and availability. The HSE is currently analysing the available sites in each location and engaging with the GPs in each location to determine their interest in participating in the primary care centre development.

GP Contract Issues
The Department and the HSE are currently examining the changes that need to be made to the GMS contract to facilitate the introduction of Universal Primary Care. As part of this process, the Department has held discussions in relation to competition law with the
Department of Jobs, Enterprise and Innovation, the Department of Public Expenditure and
Reform and the Competition Authority. There have also been preliminary discussions with
the Irish Medical Organisation (IMO) to outline policy in this regard. It is expected that there
will be further discussions once the legislation regarding the extension of free GP care is
published.

Resource Allocation
In order to support rational and equitable development of primary care teams, the HSE has
developed a Resource Allocation model based on deprivation and need. This provides an
objective, transparent mechanism for the allocation of posts in primary care.

Using this model, the HSE has completed a detailed analysis of the numbers and distribution
of public health nurses, registered general nurses, occupational therapists, physiotherapists
and speech and language therapists. The analysis reveals considerable variation across the 17
Integrated Service Areas in ratios of health care professionals to population, and to
population numbers in areas of high deprivation.

Based on this analysis, it is intended to recruit a range of additional posts as soon as possible
in 2013, as follows:

- 70 Public Health Nurses
- 37 Registered General Nurses
- 51 Occupational Therapists
- 46 Physiotherapists
- 47 Speech & Language Therapists

3.4 Next Steps
Immediate next steps under this workstream include:

- the completion of legislation providing for the extension of free GP care, after which
  implementation dates will be determined;
- the assignment of 17 Integrated Care Diabetes Nurse Specialists to HSE areas; and
- in line with overall governance measures, the appointment of a National Director for
  Primary Care.

There will also be ongoing work in 2013 to develop primary care infrastructure, fill new
primary care posts, and develop a new GP contract.

Finally, as noted in Chapter 8, work on reforming health sector governance and
organisational structures during 2013 will encompass a review of Integrated Service Areas
which will help to inform new structures for the delivery of primary care. Future work will
also need to contemplate the organisation of primary and community care in the future UHI
landscape.
4. Hospital Structures

4.1 Broad Description of the Workstream
The overall objective of the Hospital Structures workstream is to fulfil the Programme for Government commitment to transform public hospitals into independent, not-for-profit trusts. The workstream firstly involves organising every public acute hospital in Ireland into a set of Hospital Groups under a single management structure; a process which must take account of the key principles and criteria set out in the Framework for Smaller Hospitals. Thereafter it will be necessary to establish the legislative framework governing Hospital Trusts and to agree an implementation process for the formal establishment of Trusts. This will require strong engagement with work under the Regulation of Healthcare Providers workstream in terms of (i) the process of authorisation associated with gaining ‘Trust’ status and (ii) ongoing regulatory requirements and powers.

4.2 Guiding Objectives for the Workstream
The overall aim of projects under this workstream is:

✓ to establish new organisational and accountability arrangements for hospital services so as to support improved hospital performance and, ultimately, improved patient outcomes; and
✓ to support the move towards a universal insurance-based health system where insurers purchase care on behalf of all citizens from independent healthcare providers.

4.3 Progress to Date
Development of Hospital Groups
In June 2012, the Minister for Health appointed Professor John Higgins to chair a Strategic Board on the Establishment of Hospital Groups. The Strategic Board consists of representatives with both national and international expertise in health service delivery, governance and linkages with academic institutions.

A Project Team was established to make recommendations to the Strategic Board on the composition of Hospital Groups, governance arrangements, current management frameworks and linkages to academic institutions. The Project Team carried out a comprehensive consultation process with all acute hospitals and other health service agencies, involving over 70 meetings and numerous written submissions.

Following this consultation process, the Project Team produced its Report on the Establishment of Hospital Groups and its recommendations have been endorsed by the Strategic Board. The final report has been submitted to the Minister and will be considered by Government whose decision on the composition of Hospital Groups will be informed by
it. In line with the Cabinet’s decision on the composition of Hospital Groups, these groups will then be established on an administrative basis in the first instance.

As highlighted in 4.1 above, the development of Hospital Groups must be undertaken in accordance with the key principles set out in the Framework for Smaller Hospitals.

**Evidence Review on Hospital Trusts**

Parallel with the work on Hospital Groups, the Department asked the Health Research Board to undertake an *International Evidence Review on Independent Hospital Trusts*. This review was submitted to the Department in October 2012 and highlights a number of important considerations.

It found that independent hospitals, operating as legal entities responsible for their own governance and finance, have had some success in England but not in New Zealand or Scotland.

The documented factors which facilitated success in England included the fact that there was a united vision and ethos, a large stable pool of funding, a successful internal market as a result of population density and a number of services that could provide the same treatment within easy reach. Importantly, there was also a very clearly designed process for establishing, governing, developing and monitoring Foundation Trusts. Indeed, the large volume of legal and regulatory work associated with the establishment of such trusts, and the critical role of regulatory authorities such as Monitor, the Care Quality Commission and the National Audit Office, is notable.

New Zealand, a small country with low population density, experienced a number of difficulties establishing independent healthcare providers and more recent reforms have seen a return to a regionalised system and a weakening of the purchaser/provider split. The literature offers a number of reasons for this, noting that an internal market and competition between providers and commissioners was not viable in the New Zealand health sector, the anticipated customer choice had not occurred and the independent providers quickly accrued financial debt. The operation of trusts in Scotland experienced similar issues and the *National Health Services Reform (Scotland) Act 2004* abolished the NHS trust and internal market approach in Scotland.

These important findings will inform the detailed design of Hospital Trusts in Ireland, the associated implementation structures and processes, and the wider contextual factors which need to be considered. To that end, the review also notes that, alongside and integral to the success or failure of independent hospital entities, a number of strategies were introduced to manage healthcare cost increases in OECD countries. The cost saving strategies included care at the appropriate level, the creation of an internal market, strategic purchasing, and public private partnerships.
4.4 Next Steps

Immediate next steps include:

- the creation of Hospital Groups on an administrative basis in the first quarter of 2013; and
- the establishment of a National Steering Body to provide guidance on the formation of Hospital Groups and to issue specific implementation guidelines on the steps required to give effect to groups.

Subsequent actions include:

- in line with the principle of ‘reform, learn, reform’, reviewing the operation of Hospital Groups to establish what changes, if any, are required prior to moving to Hospital Trusts;
- taking account of international experience, developing the policy and legal framework for the creation of Hospital Trusts; and
- commencing the process of authorisation for gaining ‘Trust’ status
5. Hospital Financing

5.1 Broad Description of the Workstream
The overall purpose of the Hospital Financing workstream is to support the ultimate delivery of a single-tier system where every patient is funded on an individual ‘Money Follows the Patient’ basis. As such, the Hospital Financing workstream involves the introduction of a ‘Money Follows the Patient’ financing mechanism for public patients and the introduction of a corresponding charging regime for private patients in public hospital care. This work also includes developing proposals for the creation of an interim purchaser of hospital services for public patients and then working in tandem with the PMO and others to implement those proposals. Finally, as the reform agenda advances, this workstream will evolve to encompass issues relating to the ultimate move to an integrated, single-tier UHI system and the strategic purchasing role of the proposed Insurance Fund within that system.

5.2 Guiding Objectives for the Workstream
The overarching objectives for this workstream are:

✓ to have a fairer system of resource allocation whereby hospitals are paid for the quality care they deliver;
✓ to drive efficiency in the provision of high quality hospital services;
✓ to increase transparency in the provision of hospital services; and
✓ to support the move to an equitable single-tier system where every patient is insured and has their care financed on the same basis.

The ultimate goal is to have a value-based purchasing system which allows money to follow the patient to the most appropriate care setting. The system must seek to align incentives so as to encourage quality, continuous care across settings and support good health outcomes across the whole population. As such, the Hospital Financing workstream will have to be progressed in close conjunction with primary care reform, with both workstreams, in turn, being guided by work on overall UHI design.

5.3 Progress to Date
Development of ‘Money Follows the Patient’ Policy
In April 2012 a Hospital Financing Subgroup, comprising Departmental, HSE and hospital representatives, was established under the auspices of the UHI Implementation Group. This subgroup has worked intensively to develop draft policy proposals on ‘Money Follows the Patient’.

In order to best deliver on the objectives of fairness, efficiency and transparency outlined above, the policy proposals advocate the introduction of a prospective, case-based payment
system (a Diagnosis Related Group system) to replace the current block grant allocation mechanism for public hospitals. The proposals also detail the services to be covered by the ‘Money Follows the Patient’ system, how these services should be defined, the manner in which prices should be set, the purchasing and price-setting structures which need to be established and the overall contracting and payment process. They then map out the major building blocks and system capacity which must be developed in order to introduce the new funding model, and the key contextual constraints and interdependencies which must be factored into the implementation plans, including policy and timing in relation to Hospital Groups. The proposals conclude by outlining initial plans for introducing ‘Money Follows the Patient’ shadow funding of inpatient and daycase care in 2013, with full phased implementation of the new funding model from 2014 onwards.

The Government has approved the publication of the ‘Money Follows the Patient’ policy proposals as a draft for consultation with stakeholders. The policy is available on the Department’s website and a formal consultation process will commence shortly.

**Development of Major Building Blocks for ‘Money Follows the Patient’**

Ireland’s existing Hospital Inpatient Enquiry Scheme (HIPE) and National Casemix Programme already provide a strong platform for development of the new ‘Money Follows the Patient’ system. In addition, work has commenced on the development of several other key building blocks for ‘Money Follows the Patient’. Some of these are highlighted below.

**Electronic Claims Management Systems:**

The HSE has awarded a contract for the phased roll-out of an electronic claims management system. This system is essential for effective management of current private patient claims as well as representing a key requirement for the future single-tier insurance system. The new electronic system is currently live in twelve hospital sites with a further five expected to come on board by the end of Q1 2013.

In addition to the above initiative, the HSE has also agreed to collaborate on an eClaims project led by the health insurers, VHI Healthcare, Laya Healthcare and Aviva Health. The aim of this project is to define an industry standard for electronic direct pay claiming for those involved in hospital settings and to then drive the transition to full electronic claiming in these settings. The new industry standard is currently being piloted in two sites, the Beacon Hospital (private) and St. James’s Hospital (public/voluntary) and is progressing well.

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1 A Diagnosis Related Group (DRG) system classifies hospital activity into groups with similar resource use and clinical characteristics. As such, it provides a transparent measure for reporting and funding hospital activity and facilitating comparisons of cost, efficiency and quality.
**Patient-level Costing Project:**
A patient level costing project is currently underway and is tracking resources used by individuals from the time of entry to the hospital until the time of discharge. This project is critical to ensuring a robust understanding of the costs of individual episodes of care at both central and hospital level.

Two costing studies were undertaken in 2012 as part of the study, one based on 2010 cost data and another on 2011 data. The 2010 costing study was completed in October 2011 and its results are currently being used in the DRG price setting process for 2013. Hospitals have also been provided with their own patient level cost data and a Qlikview support tool is currently being rolled out to assist hospitals in analysing this data effectively.

The 2011 study is still in progress with an expected completion date of early 2013. This will be followed by a further costing study on the 2012 data. It is intended that the output from both the 2011 and 2012 studies will be used to set the DRG prices for 2014.

The project has highlighted the crucial importance of developing appropriate skills and capacity at hospital level, in addition to robust patient costing and feeder ICT systems.

**Pilot Project on Prospective Funding of Selected Orthopaedic Procedures:**
A pilot project on prospective funding of selected orthopaedic procedures was initiated on 1st July 2011. The initial phase centred on the provision of primary hip and knee replacements (4 DRGs) in seven hospitals. A further five hospitals joined the pilot on the 1st January 2012. The pilot involves deducting participating hospitals’ budgets by an amount of money related to the 4 DRGs and then allowing hospitals to ‘earn’ this budget back based on care carried out.

The pilot was very positively received and demonstrated significant improvements in efficiency as measured by average length of stay and day of surgery admission rates (please see figures 2-5 overleaf). It also highlighted the importance of (i) strong engagement with stakeholders, (ii) clinical leadership at hospital and national level, (iii) clearly agreeing baseline activity so as to maintain overall financial sustainability, (iv) improving the timeliness of HIPE coding and (v) developing capacity at hospital level, particularly in relation to patient level costing so that hospitals can establish whether they are able to deliver services at the agreed price.
Figure 2: Average Length of Stay for Hip Replacement across all sites for July 2010- July 2012

Figure 3: Average Length of Stay for Knee Replacement across all sites for July 2010- July 2012

Figure 4: Day of Surgery Admission Rate for Hip Replacement across all sites for July 2010 – 2012
5.4 Next Steps

As highlighted within the ‘Money Follows the Patient’ policy paper, the immediate next steps under this workstream include:

- Consultation with stakeholders on the policy, and detailed financial modelling and planning in order to inform a finalised policy and implementation timetable;
- Development of a corresponding charging regime for private patients in public hospitals;
- Shadow funding of Hospital Group ‘hubs’ during 2013; and
- Dovetailing with work on the creation of new Hospital Groups, the development of critical infrastructure, skills capacities and business processes to enable the phased implementation of ‘Money Follows the Patient’ from 2014 onwards.
6. Regulation of Healthcare Providers

6.1 Broad Description of the Workstream
This workstream concerns the regulatory framework required to underpin the healthcare sector. As such, it encompasses the introduction of legislation which will provide for a mandatory system of licensing for both public and private health service providers. This legislation will be designed to improve patient safety by ensuring that healthcare providers do not operate below core standards. Separate from licensing legislation, regulation in relation to authorisation and ongoing monitoring of the governance of Hospital Trusts will be required (‘economic regulation’). Finally, the workstream also involves the creation of a new Patient Safety Agency.

6.2 Guiding Objectives for the Workstream
The overall aims driving initiatives under this workstream are:

- to ensure that the systems and structures required to promote and guarantee patient safety remain in place throughout the implementation of the reform process and thereafter; and
- to ensure that healthcare providers exercise good governance, thereby guaranteeing their long-term viability and availability for the communities they serve.

6.3 Progress to Date
Development of Healthcare Standards and Licensing Legislation
‘Standards for Safer Better Health Care’, which provide a national framework for good governance, patient safety and quality of care, were formally launched in June 2012. These national standards apply to all healthcare services (excluding mental health) provided or funded by the HSE.

The national standards will lead on to the development of a mandatory licensing system to be operated by the Health Information and Quality Authority (HIQA) which is due to commence on 1 January 2015 and will focus on all hospitals and providers of specialised ambulatory services such as cosmetic surgery. Work is underway within the Department of Health on a Licensing Bill to provide for the licensing system, with outline proposals due to be submitted to the Minister early in 2013. Government approval will then be sought in relation to public consultation on the draft heads of a Bill.

Governance and Economic Regulation of Healthcare Providers
In addition to upholding patient safety, there is also an important role for regulation in safeguarding good governance, financial viability and long-term sustainability of healthcare providers. The Department has engaged the Health Research Board to undertake an international review of evidence and experience in this area during 2013. The review will
outline the development of this type of regulation in health systems in a number of jurisdictions. As part of this, it will critically assess:

(i) the overarching legislative and regulatory framework,
(ii) the key features or responsibilities associated with economic regulation, and the related benefits of such regulation,
(iii) the inter-relationship between an economic regulator and other forms of health sector regulation, and
(iv) the specific role of an economic regulator in enabling the transition to Hospital Trusts.

The review will complement and build on lessons derived from the Evidence Review on Hospital Trusts (see workstream on Hospital Structures). When completed, it is envisaged that it will enable the Department to comprehensively consider the core components of health economic regulation and their application in an Irish context.

**Patient Safety Agency**

The Department is examining the appropriate structures for the responsibilities that might be assigned to the Patient Safety Agency (PSA) taking account of international experience and the existing structures and organisations in the Irish health system. The role and inter-relationship of the PSA with the reforming health system needs to be carefully designed and developed. The Department is liaising with the HSE on the details surrounding the establishment of the PSA to ensure an identifiable and distinct leadership responsibility for patient safety and quality at national level having regard to the need for a robust quality and safety function within the new delivery structures of the Reform Programme. The intention is to establish the PSA on an administrative basis in 2013.

The establishment of the agency will represent a major step in improving safety and quality. The PSA will be modelled on international examples such as the Canadian Patient Safety Institute which aims to improve the safety of patient care through learning, sharing, and supporting implementation of interventions that are known to reduce avoidable harm on the basis of partnership, working with service providers and education bodies. Its initial focus will be on leadership and capacity building for patient safety, clinical effectiveness, adverse event learning and clinical audit.

The health and social service regulatory and monitoring function will be maintained separately from the PSA and enhanced within HIQA with the latter retaining responsibility for setting and monitoring standards.

**National Clinical Effectiveness Committee**

The National Clinical Effectiveness Committee (NCEC) was established in 2011 to provide a framework for national endorsement of clinical guidelines and audit to optimise patient care. The NCEC has responsibility through its terms of reference to establish and implement explicit, transparent and robust processes for the screening, prioritisation and quality
assurance of clinical guidelines and clinical audit. National clinical guidelines will provide explicit and transparent guidance for the delivery of safe, high quality and cost-effective care. These guidelines will supersede all previous guidelines on a topic and will be utilised across the public and private healthcare system.

The national suite of clinical guidelines will provide a means of identifying the most effective interventions and/or services for a given condition. As such, they represent an important underpinning for value-based purchasing under ‘Money Follows the Patient’ and have the potential to play an important role in informing the standard package of care to be provided under universal health insurance.

It is envisaged that the NCEC will ultimately sit within the new Patient Safety Agency.

6.4 Next Steps
Some key next steps in relation to this workstream are as follows:

- Preparation of a Licensing Bill;
- Completion of an Evidence Review on Governance and Economic Regulation;
- Subject to Government approval, establishment of a new Patient Safety Agency on an administrative basis; and
- Ongoing work on developing a national suite of clinical guidelines.

Consideration will also be given to the introduction of a system of primary care accreditation. Such a system of accreditation will drive improvements in quality as well as facilitating integration within the primary care sector and between the primary care and secondary care sectors.
7. Health Insurance Market

7.1 Broad Description of the Workstream
This workstream involves fulfilling the Programme for Government commitment to introduce a permanent scheme of risk equalisation for the current insurance market, examining options in relation to the future status of the VHI and ensuring that the private health insurance market remains well regulated, and as competitive and affordable as possible, as we move towards a new system of universal health insurance.

7.2 Guiding Objectives for the Workstream
The overall aims driving initiatives under this workstream are:

- to address the current imbalance in the structure of the private health insurance market, thereby ensuring a **fair and robust community-rated market**;
- to ensure a vibrant and sustainable private health insurance market by delivering **increased efficiencies**; and
- to support the move towards a **single-tier system** where every patient is insured.

7.3 Progress to Date

Risk Equalisation Scheme
A key component to support both community rating and the operation of a stable, well-functioning health insurance market is the introduction of a permanent Risk Equalisation Scheme (RES).

The Programme for Government commitment to put a permanent scheme of Risk Equalisation in place in the private health insurance market has been achieved following the passing, in December 2012, of the Health Insurance (Amendment) Act, 2012. The new RES came into effect from 1 January, 2013 when it replaced the previous Interim Scheme. The main objective of the Act is to ensure that, in the interests of societal and intergenerational solidarity, the burden of health costs is shared by insured persons by providing for a cost subsidy between the healthy and the less healthy, including between the young and the old. As such, it seeks to strengthen and maintain stability in the private health insurance market. The new RES also allows for a greater number of risk factors than the previous Interim Scheme, including a measure of health status.

Future Status of the VHI
The Programme for Government provides for the VHI to remain in State ownership in order to ensure a publicly-owned health insurance option within the new system of UHI. This is being considered against a backdrop of the European Court of Justice Case regarding the VHI's derogation from the EU Non-Life Directives which had exempted it from the requirement to be authorised by the Central Bank.
The European Court of Justice found that Ireland failed to fulfil its obligations under various EU directives in relation to the health insurance market by exempting the VHI from being regulated (i.e. holding an authorisation) by the Central Bank of Ireland. In order to address the Commission’s concerns, the Government has agreed to resolve this issue.

To achieve authorisation, the VHI will require capitalisation and a sustainable business plan which, in turn, depends critically on a properly functioning RES. The European Commission has a particular interest in this area from competition, State Aid and single market perspectives. It also considers that the VHI effectively enjoys an unlimited State guarantee, a claim rejected by Ireland. However, in order to address the Commission’s concerns, the Government has agreed to resolve this issue.

Department officials have been engaged in negotiations with the European Commission (both the Directorate General for Internal Market & Services, and the Directorate General for Competition) in relation to all three interrelated issues (i.e. risk equalisation, the unlimited State guarantee and the authorisation of VHI), and agreement has been reached on the resolution of an alleged unlimited guarantee to VHI.

VHI will establish a new corporate structure within the parameters of its governing legislation involving the establishment of a number of incorporated subsidiaries to undertake health insurance and other business. The incorporated health insurance business will take over from the Statutory Board of the VHI on the date of its authorisation by the Central Bank of Ireland. The Department has outlined to the Commission that this would take place on or before 31 December 2013 subject to the granting of the Irish Government’s approval for authorisation. The Irish Government has also provided the Commission with copies of the formal exchange of letters between the Minister for Health on behalf of the Government and the VHI confirming that no unlimited State guarantee exists.

Finally, VHI has been in focused planning discussions with the Central Bank of Ireland regarding the process involved in making an application for authorisation. There are two main strands to the authorisation process. The first strand is prudential, i.e. related to solvency, and the second relates to the qualitative or corporate governance measures. Good progress has been made by VHI in relation to a number of structural and corporate governance issues which are required of an authorised entity, including the new ‘qualitative’ requirements which will be imposed on all insurers, arising from the new EU SOLVENCY II regulatory regime.

**Statutory System of Health Insurance**

The Programme for Government envisages a statutory system of health insurance, guaranteed by the State, in which the UHI system will not be subject to European or national competition law. The legal and practical requirements of this approach are likely to be very complex. These areas are being explored in the context of work on overall UHI design (see chapters 9 and 10) and the Government will make a decision on the best way forward as soon as
possible. Any decision must take full account of the need to address the European Court of Justice judgement comprehensively by the end of 2013.

Affordability in the Private Health Insurance Market
There is strong consensus across stakeholders on the need to safeguard the affordability of private health insurance. Accordingly, a Consultative Forum on Health Insurance was established in 2012 to discuss ideas for achieving cost savings and reducing the cost of health insurance overall. The Forum has sought to identify ways of addressing costs throughout the industry, whilst always respecting the requirements of competition law. In addition to plenary sessions of the Forum, bilateral meetings have taken place with each insurer where they have brought forward their own ideas for cost savings in the market. These ideas are the subject of ongoing deliberation and policy analysis within the Department.

The Forum also provides a vehicle for engagement and consideration of issues relating to the implementation of UHI and, in the more immediate term, the introduction of risk equalisation. In particular, the Forum provided a valuable platform during 2012 for insurers to directly contribute to discussions around the planned working of the RES and the Minister was pleased to include some legislative amendments proposed by insurers as part of this process. The Forum will continue to meet during 2013 to discuss appropriate measures to help address costs in the industry.

In addition to the general work of the Forum, the Department continues to concentrate on the need for VHI to address its costs. The VHI has also been strongly focused on this aspect of its business and an external review of its claims costs is nearing completion.

The VHI recently reported that its cost containment programme has saved €200m since 2009 by applying various cost containment measures including:

- Reducing consultants fees by 15%
- Reducing the prices its pays for various procedures by between 13% and 53%
- Introduction of a revised payment system for Radiologists and Pathologists.

The VHI is also focused on claims recovery through the work of its Special Investigation Unit, which has resulted in savings of approximately €7m during 2011.

7.4 Next Steps
Immediate next steps in relation to this workstream include:

- Continued work by the Department and the VHI in relation to the latter’s application process for authorisation by the Central Bank of Ireland. The aim will be to reach the point of authorisation, subject to a final Government Decision regarding capitalisation of VHI, by the end of 2013. The process is dependent on decisions, not only of the
Government, but also of the European Commission (in relation to State Aid issues) and the Central Bank of Ireland as the independent Irish financial regulator.

- Continued exploration of the legal and practical requirements associated with a statutory system of health insurance which is not subject to European or national competition law as envisaged in the Programme for Government.

- Continued focus on the issue of costs through 2013 and beyond. In the case of VHI, this will involve completion of the external review and the implementation of its findings. Given VHI’s very significant share of overall costs in the market, specific areas which it will need to address include:
  
  - Audit of the volume of procedures;
  - Clinical audit to determine the appropriateness of procedures being claimed for;
  - Benchmarking to determine why VHI is paying what it is paying for procedures at the current rate, i.e. base costs, and consider how to drive down costs in this area.

In addition, the Minister has asked VHI to submit a detailed cost containment plan, which is in preparation, with clear targets and timelines under each heading; he has made it very clear that VHI must aggressively cut its cost base so as to minimise the need for any future premium increases.

- Following consideration of how the market is operating under the new RES and receipt of a Report from the Health Insurance Authority later this year, the preparation of primary legislation in 2013 to give effect to the appropriate RES credits which should apply to ensure the maintenance of a balanced, healthy private health insurance market.

- Ongoing consideration of any measures deemed necessary to assist with ensuring the maintenance of a healthy and functioning private health insurance market, including the introduction of Lifetime Community Rating and the introduction of a standard plan/core set of benefits for the current market.
8. Enabling Change

8.1 Introduction
Chapters 3 to 7 consider all of the major elements which must come together to create the future UHI landscape. However, successful delivery of reform is also contingent on a number of critical enabling factors. These ‘change catalysts’ are key to supporting transformation across the whole health system and include:

- unique identifiers,
- common datasets,
- systematic improvement of clinical and operational processes through the work of the Special Delivery Unit and the National Clinical Programmes, and, most importantly,
- a flexible, motivated and skilled workforce.

This chapter briefly reviews a number of these enablers.

8.2 New Transitional Governance Structures
Having effective structures in place with strong governance and management provisions is fundamental to achieving the objectives set out in the health reform programme. As noted in Future Health, the aim is to implement the necessary structural reform on a phased basis.

Work is already underway to implement the first phase of new governance structures which will provide for strengthened accountability for the HSE to both the Minister and the Department, in line with the commitments set out in the Programme for Government.

The Health Service Executive (Governance) Bill 2012 was published in July 2012. It provides for the abolition of the Board of the HSE and its replacement by a new governance structure. The Board will be replaced by a Directorate, headed by a Director General and including directors drawn from HSE senior managers. The Directorate will be accountable to the Minister for the performance of both its own and the HSE’s functions. As Chairperson, the Director General will account to the Minister on behalf of the Directorate in relation to the HSE’s performance. S/He will do this through the Secretary General of the Department.

The National Directors will be responsible for the delivery of services within their particular service areas and will have a clear mandate to drive sustained performance improvement. This will involve the development of strengthened frontline provider structures, while simultaneously establishing enhanced accountability arrangements via new performance contracts, underpinned by ‘Money Follows the Patient’ funding systems where appropriate. As such, the new governance arrangements are designed to aid development of the new organisational structures and financial systems delineated in chapters 3 to 5, thereby preparing the system for the overall move towards UHI.
Figure 6: Planned Phase 1 Governance Structures

*Note it is intended that the Child and Family Support Agency will be established in 2013.

In order to ensure a co-ordinated approach to service delivery, a review of Integrated Service Areas (ISAs) will be conducted in 2013. The review will (i) ensure maximum alignment between all service providers at local level, (ii) review executive management and governance arrangements, and (iii) inform new structures for the delivery of primary care.

### 8.3 Special Delivery Unit

The health reform programme envisages a single-tier system where universal health insurance guarantees timely, quality care for all. Thus, achieving faster and fairer access to public hospital care is an essential prerequisite for preparing our system and ensuring it is fit for purpose in advance of the move to UHI.

The Special Delivery Unit (SDU) was established in the Department of Health in June 2011 with the objective of driving down waiting times for both scheduled and unscheduled care in Irish hospitals and introducing a major upgrade in the performance capabilities of the Irish health system.

Since its establishment, progress has been made on tackling waiting lists for inpatient, outpatient and daycase treatment (scheduled care) and long waits in Emergency Departments (unscheduled care). The SDU has put in place major national programmes to assist hospitals in addressing problems associated with delays in accessing care. Ambitious targets have been set for hospitals and these are being rigorously monitored on an ongoing basis.
8.3.1 Waiting Times – Unscheduled Care.
The total number of patients waiting on a trolley in 2012 was 23.6% less than in 2011. This equates to almost 20,352 fewer people waiting on trolleys. Among the factors that are having a positive impact on patient experiences in Emergency Departments are the appointment of additional consultants in Emergency Medicine, the introduction of new governance structures in all Emergency Departments and the implementation of the National Acute Medicine Programme which aims to optimise and standardise the management of acutely unwell medical patients. In addition, under the National Emergency Medicine Programme, standardised clinical guidelines, protocols and tools to enhance patient care will be implemented in the coming 12 months which should further contribute to improved patient access and service quality.

8.3.2 Waiting Times – Scheduled Care

**Inpatient/daycase**
The inpatient/daycase access targets for 2012 and the public hospital system’s progress against these targets is set out below.

**Target:** No adult should wait more than 9 months for an inpatient/daycase procedure
**Result:** The number of adults having to wait more than 9 months for inpatient and day case surgery was down from 3,706 in December 2011 to 86 at the end of December 2012, a 98% decrease.

**Target:** No child should wait more than 20 weeks for an inpatient/daycase procedure
**Result:** The number of children waiting over 20 weeks was down from 1,759 in December 2011 to 89 at the end of December 2012, a 95% decrease.

**Target:** No patient should wait more than 13 weeks for a routine GI endoscopy
**Result:** The number of patients waiting over 13 weeks for a routine endoscopy procedure was down from 4,590 in December, 2011 to 126 at the end of December 2012, a 99% decrease.

**Outpatient Waiting Times**
Much work has been done in relation to developing and implementing standardised reporting of outpatient waiting times through the HSE Outpatient Data Quality Programme. The SDU together with the National Treatment Purchase Fund (NTPF) will build on the work already undertaken by the HSE and ensure that individual patient-level data are available at a national level from all hospitals. The collation and analysis of such data in a standardised format will show the distribution of long waiters across all hospitals and allow the SDU and NTPF to target resources towards those patients who are waiting longest and ensure that they are seen and assessed.
During the period 2013-2015, the HSE, together with the SDU and the HSE Clinical Programmes, will reform the structure, organisation and delivery of outpatient services to ensure that the right patient is seen and assessed by the right health professional at the right time. Key elements of this programme of reform will include on-going validation of waiting lists, the systematic and standardised management of referrals from primary care, a reduction in unacceptably high ‘do not attend’ rates and appropriate discharging from outpatient services when clinically appropriate to do so.

The HSE/SDU maximum waiting time targets for first time outpatient appointments are:

- 12 months by 30 November 2013;
- 26 weeks by 30 November 2014, and
- 13 weeks by Nov 2015.

### 8.4 National Clinical Programmes

Over the past number of years, the HSE has undertaken significant work to develop and roll out National Clinical Programmes. These programmes provide a national, strategic, standardised and co-ordinated approach to a wide range of clinical services.

There are currently over 30 Clinical Programmes at various stages of development/implementation (see Figure 7). Many of the programmes have produced models of care and guidelines which have been jointly agreed and endorsed for implementation with the colleges.

The Clinical Programmes have 3 main objectives:

- Improve **quality** of care delivered to all users of HSE services;
- Improve **access** to all services; and
- Improve **cost effectiveness**.

The application of the programme approach aims to improve disease management and patient care by putting the patient at the centre of care, by providing for clinical accountability and by achieving clinical leadership and buy-in. The implementation of clinical models also ensures that forecasted benefits are delivered and that continuous improvement is sustained.
Figure 7: National Clinical Programmes

National Clinical Programmes

- Unscheduled Care
  - Acute Medicine
  - Emergency Medicine
  - Surgical (Elective & Acute)
  - Anaesthetics
  - Retrieval & Transport
  - Orthopaedics (Inc Trauma & Elective)
  - Critical Care

- Diagnostic / Support Services
  - Radiology
  - Pathology (Guidelines)
  - Blood Transfusion / Haemachromatosis
  - Audiology
  - OPAT
  - Endoscopy

- Primary Care Programme
  - GP Co-Leads

- Long Term Conditions (Acute to Community)
  - Respiratory (COPD, Asthma, Cystic Fibrosis)
  - Dermatology
  - Rheumatology / Musculoskeletal
  - Renal
  - Mental Health
  - Rare Diseases
  - Rehab Medicine
  - Palliative Care
  - Care of Older People
  - Ophthalmology

- Cross Programme Initiatives
  - Outpatient Services
  - Health Informatics / Intelligence / IT
  - Quality Improvement
  - Chronic Disease Prevention
  - Integrated Care (long-term conditions)
  - Standards & Guidelines
  - Medicines Management
  - HCAI
  - Advocacy Engagement

- Women & Children
  - Obstetrics & Gynaecology
  - Paediatric & Neonatology

- Cardio / Cerebro-Vascular Disease
  - Stroke
  - Heart Failure
  - ACS
  - Diabetes
  - Neurology
  - Epilepsy
8.5 Health Information and ICT

High calibre health information will be the lifeblood of quality, safety, payment and other regulatory processes within the future health landscape. It will also be central to delivering responsive, integrated care across multiple settings. Having good quality health information, and effective ICT systems that facilitate the efficient collection, analysis and use of such information, is, therefore, critical for enhancing the overall capacity and performance of the health system and facilitating implementation of the reform programme.

It is acknowledged that major developments will be needed to tackle the capacity deficit in information and ICT. While some progress has been made in addressing information deficits and information standards, including work undertaken by HIQA, significant improvements will be needed to deliver the patient-level information flows necessary for reform implementation purposes.

8.5.1 Health Information Bill

The Health Information Bill, which is currently being drafted, will provide a legislative framework for better governance of health information. The Bill will provide a legal framework for the introduction of an individual identifier for use in the health system. There are also provisions for identifiers for healthcare organisations.

In addition, the Bill will establish a standards-based approach to supporting inter-operability between computer systems. This is in place of a National Electronic Health Records System which international experience shows is costly and may not bring the expected benefits. The Bill also supports a standards based approach to health information management so that health information can be quality assured throughout the health system. Other initiatives in the Bill include provisions for data matching and health information resource programmes (population registries).

8.5.2 Information and ICT Strategy

The Department of Health will develop an eHealth Strategy in conjunction with the HSE. The Strategy will provide a framework for the design and implementation of eHealth systems to support and enable the delivery of integrated care under the reform agenda. The Strategy will be completed in the first half of 2013.

In order to realise the eHealth Strategy and ensure that the necessary information, technical and governance structure is in place, an Information and ICT Strategy Unit, led by a Chief Information Officer, will be established in the first half of 2013. An Information and ICT Advisory Committee, which will include appropriate outside expertise, will also be formed to support the Strategy Unit.

It is widely understood that significant investment in ICT capacity and delivery capability will be required to support the reform agenda.

2 The development of identifiers for use in the health sector will take full account of the public services card.
8.6 Human Resources

The Public Service Agreement (‘Croke Park Agreement’) has been identified as critical to advancing the health reform agenda and responding to the healthcare needs of the population in an appropriate and sustainable manner. Notably, it has facilitated delivery of health services against a backdrop of cumulative budget and staffing reductions.

Since 2010 the Agreement has helped the health sector to manage the reduction of staff numbers by over 8,200 whole-time equivalents (WTEs). Evidence of the value of the Agreement, in particular its flexibility provisions, can be seen in terms of the response of the system during the ‘Grace Period’. In the six months to the end of February 2012, some 3,000 (WTE) staff members retired from the health service and all key services including maternity, critical care, neonatal and essential social services were maintained without interruption. As well as the overall reduction in numbers, the Agreement has facilitated the redeployment or re-assignment of some 6,900 staff across the health service.

Other reform measures include:

- reviews of rosters to optimise efficient delivery of services;
- an extended working day for hospital laboratory and radiography services;
- agreement to major work practice changes for consultants; and
- co-operation by staff with clinical care changes in hospitals, in particular under the Acute Medicine Programme and the Productive Operating Theatre system.

The Public Service Agreement will continue to be used to the fullest extent possible to protect health services and to facilitate implementation of the reform programme. National discussions commenced with all public service unions in January 2013, the aim of which is to achieve additional reductions in the cost of delivery of public services of the order of €1 billion and, in this context, the health sector will be required to deliver further savings.

The Health Sector Action Plan (for implementation of the Public Service Agreement) has recently been revised to reflect the fact that the health sector is moving into a further, more demanding phase of implementation of the Agreement, particularly as resources and staff numbers are further reduced. This new Plan contains measures which apply to all staff, including:

- revised rostering arrangements, increased use of redeployment and implementation of revised sick leave rules, adopting flexible models of care and changes to skill-mix, increased use of shared services and external service delivery arrangements; and
- co-operation with new governance and management structures at national and other levels, including establishment of Hospital Groups.

It also sets out specific measures relevant to particular disciplines or staff groups such as consultants, nurses and allied health professionals.
9. Designing a Universal Health Insurance Model for Ireland

The previous chapters set out the core building blocks which must be put in place to prepare the system for universal health insurance, as well as the ‘change catalysts’ which will support that transformation. In addition to all of these, detailed preparatory work is required in relation to the UHI model itself. This task represents the final major workstream under the remit of the UHI Implementation Group, namely the UHI Design workstream.

9.1 Broad Description of the UHI Design Workstream
At its heart, this workstream is about the fundamental legal and structural principles which will underpin the future health system in Ireland. It is about delineating the rights and responsibilities of each and every stakeholder within our future health system from citizens to health insurers, healthcare providers, independent regulators, professional bodies and the State. This work spans six major, interconnected policy areas as outlined in figure 8 below:

Figure 8: Key policy areas within the UHI Design Workstream

9.2 International Evidence
In order to inform deliberation on the key design questions which stand to be answered as part of this workstream, Department of Health officials have reviewed a wide range of international literature on insurance-based health systems. Some of the main findings and significant considerations which have been gleaned from this work are summarised below.
Types of Multi-Payer Model
The Government is committed to the introduction of a multi-payer insurance model. In order to design the optimal multi-payer model for Ireland, the Department has explored multi-payer insurance systems in a number of other countries. These systems can be broadly grouped into five categories or typologies.

The first type can perhaps be described as the traditional social health insurance model with universal coverage of the population by non-competing insurers, insurance contributions linked to ability to pay and resources largely raised through payroll contributions and taxation. Examples of such systems include France and Japan.

There are also competitive social health insurance models where insurers operate as largely independent, ‘not for profit’ entities and provide universal coverage of the population. Under this model, insurers are also predominately funded via payroll and Exchequer contributions and are often not subject to EU competition law. However, they are allowed to compete for customers with citizens offered a choice of insurer and a right to switch periodically. The Czech Republic offers an example of such a system.

A third variation is the mixed model where social health insurance and private health insurance co-exist to provide universal coverage. Germany’s health system encompasses this blended approach. Since 2009, insurance is mandatory for all with the majority of the population automatically covered by the statutory health insurance system and free to choose from their preferred statutory fund. Others have a choice to either opt in to the statutory system or take out private health insurance. The statutory health insurance system is predominately funded through payroll contributions albeit with a notable shift in recent years towards general taxation and direct payments.

The Dutch had a mixed model but moved in 2006 to a universal insurance system operating under private law. Under this system, health insurance is mandatory for the whole population with health insurers free to set premiums and compete for customers. The system is part funded via payroll and general taxation contributions and part funded via direct premiums. Affordability of direct insurance premiums is supported by a mean-tested healthcare allowance. While the insurance market is subject to EU competition law, it is also governed by important principles of open enrolment, lifetime cover, community rating and risk equalisation, all designed to protect social solidarity. However, supplementary health insurance in respect of all items falling outside of the prescribed universal insurance package is discretionary and risk rated.

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3 Some sections of society are automatically covered by governmental schemes, eg. military, police etc. As such, these individuals cannot opt into the statutory health insurance system.

4 There are two exceptions to this. Military personnel receive care from the Dutch military medical services, while conscientious objectors pay a substitute tax in lieu of health insurance contributions. The substitute tax is held in a separate account by the Health Insurance Board and can be used to pay for healthcare costs incurred by the conscientious objector.
Finally, while the Dutch health system operates under private law, it is subject to significant Government regulation in order to protect social solidarity. By contrast, a typical **private health insurance model** involves risk-rated premiums which are freely set by the market, i.e. premiums are determined based on an assessment of each individual’s claims risk and without regard to ability to pay. Moreover, health insurers are free to refuse coverage if they believe a potential customer represents an unattractive or uninsurable risk. The health insurance market which operates in the United States of America displays some of these features. However, with the enactment of the *Patient Protection and Affordable Care Act* in 2010, sweeping reform is underway. The Act introduces universal mandatory health insurance coverage, extends financial protection and provides for important insurance reforms such as guaranteed issue and community rating.

**Basket of Services**

Universal health insurance systems generally provide coverage for a comprehensive package of primary and hospital care services. While the range of services varies from country to country, broadly speaking, such systems cover hospital services and, within the primary care sector, GP care, dental care, therapy services, maternity care, prescribed pharmaceuticals and medical devices.

While service coverage is broad, co-payments in the form of flat rate payments, percentage payments of the total costs, excess payments, etc. can apply. It is also the case that conditions and/or limitations may, in certain circumstances, attach to the availability of the services provided under the basic benefits packages. In this regard, the following restrictions and conditions are notable:

**Dental Care**

In some of the countries reviewed, dental services are, except in limited circumstances, excluded from the basic package of services. Examples of such countries include Estonia where adult dental care is excluded and Israel where all dental care is excluded, except for maxillofacial surgery in trauma and oncological cases, and dental care for oncology patients. In other cases, the basic package of services for those under 18 years of age can be more extensive than that applying to those aged 18 years and older. For example, in the Netherlands, dental care for those in the older age group is limited to specialised surgical dentistry (oral surgery) and the associated x-rays and dentures.

**Pharmaceuticals**

Prescribed pharmaceuticals are generally covered by the basic package of services although co-payments can apply. In addition, some countries, for example, Germany and the Netherlands, have reference pricing systems which define a reimbursement limit for groups of comparable drugs. The insured person must pay for costs in excess of the reference price, in addition to co-payments where applicable. Non-prescribed over the counter (OTC) products tend not to be covered.
**Paramedical Services**

In general, paramedical (i.e. therapy) care is included in the standard package subject to referral for such services by a doctor. In the Netherlands, the entitlement to physiotherapy for those over the age of 18 years is limited to treatment of certain chronic conditions, excluding the first nine treatments for each disorder. Those under 18 years of age are entitled to nine treatments per year for each disorder which may be extended by another nine treatments\(^5\).

Finally, there would appear to be some consensus in relation to the services that are excluded from the standard benefits basket in the different countries reviewed. In the main, these include cosmetic surgery, products deemed not medically necessary, OTC drugs, vaccinations for travel and medical certificates. In certain countries, preventive health measures such as vaccination and screening programmes may also be excluded on the basis that such programmes concern population health and are, therefore, funded directly from general taxation. That said, the standard package of services is also a product of each country’s culture and value system. For example, the reimbursement of complementary treatments such as homeopathy, acupuncture and neural therapy in Switzerland is almost unique in Europe, presumably indicating strong public desire for such treatments. The reimbursement of balneotherapy (spa treatments) in Germany similarly represents traditional values in the country.

**Process for Determining the Standard Basket of Services**

The establishment of a robust and transparent process for determining the standard basket of services will be central to the success and sustainability of the future UHI system in Ireland. In acknowledgment of this, the Department undertook a detailed examination of international evidence on approaches to planning and priority-setting. In addition to reviewing approaches to planning and priority-setting at national level, the examination also sought to distil a set of best practice principles to guide national planning and priority-setting in Ireland before briefly considering their application in the future UHI system.

Priority-setting is a systematic approach to distributing limited resources between competing demands in order to achieve the best health outcomes in an efficient and sustainable manner. The evidence review found that that priority-setting is not a ‘one-size-fits-all’ process. However, it nonetheless proposed the development of best practice principles comprising:

- transparency,
- determination of values, and
- impact on policy,

as a good starting point upon which to build a national priority-setting framework.

\(^5\) The standard package provides more comprehensive coverage in the case of certain restricted disorders.
In particular, the study suggested that the principles of transparency and determination of values could usefully underpin the process for defining the standard health basket. Mechanisms to facilitate transparency might include the appointment of members of the public to any entity charged with helping to determine the composition of the standard basket, the disclosure of possible conflicts of interest by all individuals involved in helping to determine the composition of the basket, and the systematic disclosure of the basis for inclusion or exclusion of services from the standard basket. Public values should also be taken on board albeit that this will have to be balanced with a requirement to consider difficult policy decisions and trade-offs.

In this regard, the role of health technology assessment is vital in determining the relative cost-effectiveness of medical interventions and providing a robust evidence base to inform subsequent coverage decisions. The generalised cost-effectiveness analysis framework (GCEA) is also considered a useful tool for analysing treatments that are most cost-effective.

Finally, having established a robust process for determining the services to be included in the standard basket, it is also necessary to consider the approach for delineating those services, i.e. defining the scope of the standard health basket. To this end, the study indicates that a positive list approach (i.e. defining all treatments, interventions, pharmaceuticals and other services to which people are entitled) or a negative list approach (i.e. stipulating all services not covered by the scheme) can be used. It is notable that, in defining the detailed benefits covered by universal insurance systems, many countries appear to adopt both approaches.

**Raising Resources**

Decisions on coverage cannot be divorced from considerations on revenue, i.e. the mechanisms by which we pay for the basket of services. This section briefly outlines common trends in relation to funding of universal insurance-based health systems.

Payroll-related social insurance contributions represent the predominant funding source across the countries reviewed⁶. This is usually broken down into an employer and an employee contribution. However, the vast majority of countries raise revenue from multiple sources and there is a notable trend overall towards diversification of the funding base. In particular, a significant shift towards general taxation can be discerned. In some cases this is used simply to supplement the funding base while, in others, it is explicitly linked to covering the health insurance costs of the economically inactive.

General taxation can offer a number of important benefits. Firstly, it offers a considerably broader funding base than payroll-related contributions which are essentially limited to earned income. This is vital in a time of ageing societies with a corresponding shrinking labour market and growing dependency ratio. However, it is also considered important from

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⁶ In Israel, the health insurance system is financed primarily through a combination of earmarked taxes and general taxation. In the USA, the Medicare system is financed through a combination of payroll contribution, premiums and general taxation, while Medicaid is financed via Federal and State taxation.
the perspective of economic competitiveness. This is because a shift to general taxation mitigates the burden on labour. Indeed, the importance of protecting competitiveness in the face of rising healthcare costs is apparent in recent policy decisions across a number of countries where employer contributions have been frozen, or even reduced, while the funding share from general taxation has increased.

In addition to the benefits outlined above, in cases where general taxation is allocated on the basis of an explicit formula or earmarking principle (e.g. a fixed contribution to cover the cost of each person who is economically inactive), this can ensure counter-cyclical stability and mitigate the impact of funding fluctuations associated with increases in unemployment. At a general level, it also guarantees dedicated revenues, thus supporting effective planning and commissioning of sustainable, reliable health services\(^7\).

Finally, as all health systems grapple with issues of cost containment and sustainability, a notable trend appears to be an increase in the use of co-payments. While co-payments serve to raise revenue, the policy rationale for their introduction often appears to relate to reducing inappropriate use and containing costs.

**Principles in relation to Revenue Raising**

How you raise resources can affect the efficiency, effectiveness and equity of your health system, and can also have wider economic impacts. To this end, the European Observatory on Health Systems and Policies, in conjunction with the World Health Organisation, recently identified the following core principles in relation to raising revenue for healthcare\(^8\):

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

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

- **Fairness with respect to the burden of financing health services**
  OECD research has found that direct taxes and social insurance contributions are progressive while out of pocket payments are always regressive\(^9\).

- **Efficiency and transparency**

\(^7\) A key lesson from the literature seems to be that, successful introduction of an insurance-based system doesn’t necessarily need a dedicated or earmarked tax but does need stable, dedicated revenues which purchasers can depend on when negotiating contracts.


\(^9\) It also found that private health insurance contributions are often regressive but this can depend on whether such contributions are mandatory and matched with a system of financial support for those on lower and middle incomes.
The collection of revenues incurs administrative costs and, so, consideration must be given to the most efficient mechanisms for raising revenue. In addition, public acceptability of revenue raising mechanisms can be greater where there is transparency and satisfaction with respect to how that revenue is spent.

- **Non-health concerns such as impact on wage competitiveness**
  As noted above, demographic and economic considerations must also be taken into account when evaluating approaches to revenue raising.

The above principles provide a robust analytic framework for developing detailed policy proposals on the issue of raising revenue under UHI.

**Payment Mechanisms**
Purchasing mechanisms can be a powerful tool for supporting and incentivising the delivery of better quality healthcare. In order to maximise the contribution that purchasing can make in this regard, the *World Health Report 2000 - Health Systems: Improving Performance* advocated strategic purchasing as a means of improving the performance of health systems. Instead of a passive approach involving, for example, reimbursing for services retrospectively, strategic purchasing requires a proactive approach in relation to decisions about which services should be bought, how and from whom. The concept encompasses both the strategic use of service contracts and the strategic selection of payment mechanisms in order to achieve health policy goals.

In relation to the purchase of health services in countries that have insurance-based health systems, it is possible to discern particular trends.

**Hospital Services**
In the case of hospital care, the main trend has been to move from fixed block grant allocations and/or per diem payment systems to prospective Diagnosis Related Group (DRG) case-based payment systems where hospitals are paid on the basis of the actual care delivered. The main reasons for introducing such systems are to drive efficiency and increase transparency. Countries that have moved to DRG-based funding systems include Germany, the Netherlands, France, Estonia, Czech Republic, Slovakia, Poland and Israel.

As noted in section 5, Ireland also plans to introduce a prospective DRG case-based system as part of its new ‘Money Follows the Patient’ funding model.

**Primary Care**
On the primary care side, various payment methods apply, including fee-for-service, capitation and salary.

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10 The Netherlands is moving progressively to a competitive pricing model, where procedures are classified using a DRG-type system but are, to an increasing extent, freely negotiated between insurers and hospitals.
Fee-for-service involves a payment for each unit of service provided and is intended to provide doctors with the flexibility to respond to patients’ needs. Capitation comprises payment for the care of individual patients for a particular period of time and is independent of the extent of services individuals require, although it is often risk-adjusted. Finally, a salary-based payment approach relates to units of the healthcare professional’s time and is independent of the volume of services provided or the number of patients treated.

It is acknowledged that no single payment method is best placed to fully achieve the objective of cost-effective delivery of high quality patient care. Each of the foregoing methods can affect provider behaviour in both positive and negative ways. Perhaps for this reason, at European level, there has been a move towards mixed payment systems (Netherlands, Czech Republic, Hungary, Slovakia and Slovenia). The evidence underpinning the Report of the Expert Group on Resource Allocation and Financing in the Health Sector noted that mixed systems which have a large prospective component seem to be more successful in achieving the overall health policy objectives. It also noted that the challenge is to provide the necessary incentives for improved efficiency and quality while maintaining the prospective nature of payment so as to ensure financial sustainability.

**Integrated Healthcare**

Integrated health care involving the coordination of care across a range of providers is increasingly being recognised as fundamental to addressing the needs of those with chronic diseases, multiple complex health issues and frail older people. In order to incentivise this model of care, many countries are redesigning their payment systems. In each case, the objective is to use the payment mechanism as a means of supporting joined up, continuous care, and to shift the focus from rewarding activity to rewarding patient outcomes.

Common trends include:

- **the earmarking of funds** to promote initial introduction of integrated care models;
- **the use of integrated care contracts** whereby purchasers contract with a single provider entity or network to provide care across traditional professional lines or settings[^11]; and
- **the use of bundled payments**. This involves making a single payment for the entire episode of care to the provider entity which is then divided among different healthcare professionals or providers along the care pathway.

[^11]: The use of integrated care contracts necessitates the development of integrated provider entities or networks with whom the purchaser can contract. In the United States of America, the Patient Protection and Affordable Care Act 2010 provides for a number of seminal reforms, including the creation of Accountable Care Organisations, i.e. networks of primary care and hospital providers who agree to take responsibility for providing a defined population with care that meets specified quality targets. It also provides for the establishment of a Centre for Medicaid and Medicare Innovation to develop and test payment models for improving quality of care and lowering costs.
Some high-level examples of the use of integrated payment systems are outlined in the boxes below.

**Kaiser Permanente Medical Care Programme, USA**

The Kaiser bundled payments model is an example of a payment system that incentivises providers, in both hospital and GP-type settings, to collaborate closely in relation to the provision of health care. Under the bundled payments model, all costs associated with the range of care provided are paid to a single entity which then distributes the payment among the various providers of care.

Within the Kaiser Programme, Permanente Medical Groups (PMG) are multi-disciplinary groups of physicians who receive a fixed capitation payment to provide the full range of care. The PMG funds an incentive pool from its capitation payment which rewards staff based on meeting quality and service goals. The physicians are paid market-competitive salaries so there is no financial incentive to over treat or under treat patients. However, physicians can earn an annual performance incentive payment of up to 5% of salary based on measures of quality, service and patient satisfaction, workload and group contribution.

**Disease Management Programmes, Netherlands**

The Netherlands introduced Disease Management Programmes for those with chronic conditions, e.g. diabetes and management of cardiovascular risks (CVR). The integrated payment system, introduced in 2010, is seen as having a central role in the delivery of high quality and sustainable integrated care for those with chronic conditions. Earlier attempts at enhancing the quality and continuity of care for those with a chronic condition were hampered by fragmentary funding.

The new integrated payment system is a prospective reimbursement system. It provides an all-inclusive payment to a care group comprising multidisciplinary teams of providers in respect of the total episode of care for people with chronic conditions. Insurers purchase integrated care from care groups by negotiating a fixed price per patient per year, based on the expected case-mix of patients with a chronic disease. The price combines the costs of multiple professions working in primary care and, to a limited extent, in specialised or hospital-based outpatient care.

Finally, the international literature offers some interesting examples of other innovative mechanisms for supporting integrated, structured care. For example, in France, disease management programmes include certain preventative and patient education services which are not covered by the standard benefit package, thereby encouraging voluntary enrolment by patients. In Germany, the risk equalisation scheme is used to reinforce the drive towards disease management. It does this by linking certain health status adjustments to enrolment in a chronic disease management programme, thus incentivising insurers to fund such programmes. These examples underscore the importance of taking a coherent, ‘whole
system’ approach to our health reform programme so that incentives are aligned to maximum effect across all domains and workstreams.

The international evidence considered by the Department has highlighted a number of important principles which should underpin deliberation and decision-making in relation to both determining the basket of services and raising revenue to fund such services. It has also helped in identifying and shaping the key design questions which stand to be answered in the course of developing costed policy proposals and producing the *White Paper on Universal Health Insurance*. This is discussed further in chapter 10.
10. Developing a White Paper on Universal Health Insurance

10.1 Development of an Analytical Framework and Capacity

The Government is committed to the publication of a *White Paper on Universal Health Insurance* which will set out details of the UHI model in addition to the estimated costs and financing mechanisms associated with the introduction of UHI.

Preparation of the White Paper is a complex and technical process. It will involve significant research and financial modelling to support analysis of different design options and to help estimate the cost of different coverage and financial support systems. As a first step in this process, the Department has scoped out the major projects, studies and policy appraisals which need to be undertaken in order to produce costed policy proposals for consideration by Government. These are summarised in the analytical framework overleaf.

The framework arranges the projects, studies and policy appraisals into a series of broad work modules in order to highlight the major sequencing and interdependencies between various tasks. It also colour codes tasks as a means of identifying the key specialist skills required to deliver on each.

As a second step towards the preparation of costed policy proposals, and the related development of a White Paper, the Department is currently in the process of sourcing particular specialist skills and capacity to support delivery of each of the tasks. Some research support has been secured and detailed work on reviewing international evidence has commenced. This work will be complemented by research to be undertaken by the Health Research Board on integrating UHI services, health and wellbeing services and social care services around the needs of the patient. In addition, a tendering process to procure specialised legal research and analysis in relation to the design of the UHI model is well advanced. Additional specialised research and technical expertise will be obtained during 2013 to further advance the overall programme of work.
Figure 9: Analytical Framework: work modules and projects/studies

Evidence Generation

- 1.A. Detailed Legal Review of different UHI models. LR
- 1.B. Detailed Policy Review and Appraisal of different UHI models. DH & HE
- 1.C. Options appraisal of different purchasing/contracting approaches under UHI. HE
- 1.D. Draft Proposals on key features of UHI model. DH

Draft proposals

- 2.A. Baseline review of existing expenditure, unit costs and service volumes. TA
- 2.B. International Evidence Review on design and composition of UHI basket. DH & HE
- 2.C. International Evidence Review on Planning and Priority-setting. DH
- 2.D. High-level Policy Proposals on Standard Basket and Identification of Broad Options. DH

Costing of Proposals

- 2.E. Forecasting costs of different basket options under various scenarios. TA

Raising revenue under UHI (WM 3)

- 3.A. Review of current situation on raising, pooling and allocating resources in Ireland and a review of international approaches to raising resources in a mandatory health insurance system. TA
- 3.B. Preparation of draft proposals on raising and pooling resources under UHI. DH
- 3.C. Modelling revenue generation potential under various scenarios to support financing of different basket options. TA

UHI Financial Support System (WM 4)

- 4.A. Review of current financial support (subsidy) systems for health in Ireland. TA
- 4.B. Review of measuring incomes, and review of availability of relevant Irish data. HRB
- 4.C. Draft proposals on new financial support system. DH
- 4.D. Modelling of financial and coverage implications of different design options for financial support (subsidy) systems. TA

Legend: DH = Department of Health, HE = health economic services, LR = legal research services, TA = technical assistance services, HRB = Health Research Board.
10.2 Policy Choices and Trade-offs

In striving for the optimal single-tier health system for Ireland, there are inevitable policy trade-offs to be confronted. These trade-offs often involve tensions between efficiency and equity or between comprehensiveness and cost control. An example of the efficiency/equity trade-off might be the decision to fund services for remote island populations in order to guarantee equitable access to services for these people even though suboptimal economies of scale are involved. Examples of the trade-off between comprehensiveness and cost control include having to prioritise certain services and restrict or target others in order to remain within budget ceilings, or limiting the value of services covered by the State (via co-payments or deductibles) in order to contain costs. As we have seen from the international evidence summarised in chapter 9, all countries are faced with these choices in the design of universal healthcare systems and benefit packages.

In all cases, the trade-offs centre around three basic dimensions of the health service: the proportion of the population to be covered, the range of services to be covered and the proportion of the total costs to be met. These three dimensions, which must be confronted by all policy-makers when designing health systems, are depicted in Figure 10 below.

**Figure 10: Dimensions to consider when developing health services and health financing systems**

![Diagram of dimensions](source: WHO, 2010)

The development of detailed and costed policy proposals will empower us to understand and decide on these core trade-offs as we design the future UHI system for Ireland. As such, the work ahead, while challenging, is key to ensuring that, as a society, we can seize the opportunity to create a health service which is sustainable, equitable and there for all of us when we need it.