Crowe Horwath™

Final Report to

An Roinn Sláinte
DEPARTMENT OF HEALTH

Thematic Analysis of Submissions in Response to a Public Consultation on the White Paper for Universal Health Insurance

3rd October 2014

Contents

Appendices

Glossary

Department	Department of Health
DPS	Drugs Payment Scheme, comprising a cap for individual or family out-of-pocket expenditure of €144 per month on prescription medicines; expenditure above this threshold is covered by the State
GMS	General Medical Services Scheme, under which those on income below a specified threshold are entitled to a medical card, providing access to a range of health services free of charge
GP visit card	A card issued under the GMS Scheme to those on incomes above the medical card threshold but below a specified level, entitling the holder only to free GP visits free of charge
HSE	Health Service Executive
LTI	Long-term Illness Scheme, whereby those diagnosed with one or more specified conditions receive prescription medicines for the treatment of same free of charge
Medical card	See GMS above
PHI	Private health insurance
Universal health care / UHC	This term is used by many respondents within the submissions to the consultation process to indicate the principle outlined within the Programme for Government of a single-tier healthcare system with universal access on the basis of medical need rather than ability to pay
Universal health insurance / UHI	This term is used to describe the funding and delivery mechanisms proposed in the White Paper to deliver universal health care (UHC), by means of a competing insurance model with compulsory insurance for all individuals and households, providing access to a basket of healthcare services, with other elements of the health and social care system funded separately
PRSI	Pay-Related Social Insurance: compulsory social insurance payments paid by employers and employees to the Social Insurance Fund
USC	Universal Social Charge: a tax introduced on 1 January 2011 that replaced the income levy and the health contribution
PHN	Public health nurse
HIQA	Health Information and Quality Authority

Report Highlights

- 137 submissions were received by the Department of Health in response to the White Paper on Universal Health Insurance (UHI).
- 29% of submissions came from private individuals; 28% from advocacy, patient and public interest groups; 15% from unions or representative bodies; 12% from the education sector; and the remainder from a variety of healthcare organisations, pharmaceutical companies, health insurers, regulators, political parties and others.
- A substantial body of opinion was represented within the submissions, covering a wide range of themes. A brief overview of respondents' views is set out below.
  - Substantial demand for fairness within the health system, specifically with regard to allocation of resources and people's access to services.
  - Broad welcome for the Government's aim and intention to reform the health services to bring about a single-tier health system with equity of access, i.e. universal health care.
  - Some support, in particular from private health insurance providers, for implementing an insurance-based structure to support the aim of universal health care, along with demand for greater clarity and more detail on how UHI might work in practice.
  - Many other respondents indicated that they oppose UHI in general, and/or the particular model proposed in the White Paper, often as they see it as another form of indirect taxation; because they believe that it will lead to the continuation of a two-tier health system; or due to concerns regarding the compulsory nature of UHI.
  - Concerns that the UHI model put forward on the basis of competing insurers does not represent the best option for health service reform.
  - Concern expressed that the model selected by the Government as a basis for UHI in Ireland, as set out in the White Paper, was based almost entirely on the Dutch model without evidence of exploring other models fully, and that the Dutch model has proven to be problematic in the Netherlands due to issues around rising costs and sustainability.
  - A large number of respondents have referred to the potential for UHI to become very bureaucratic, complex and costly to administer.
  - Concerns expressed relating to potential threat to the private health insurance market in advance of the introduction of UHI, and also to the implications for those holding private health insurance policies.
  - Many respondents voiced concern regarding the impact of UHI on individual patients and families, including those currently holding medical cards, those requiring specialist high cost treatments or medicines, and those whose care involves integrated pathways across a range of treatment types.
  - There is considerable appetite among respondents for further debate and consultation in relation to UHI, and many hope that their views and opinions will be taken into account by the Department and the Minister for Health as UHI policy is further developed.

Executive Summary

Crowe Horwath was commissioned in July 2014 by the Department of Health ("the Department") to undertake a thematic analysis of submissions received as part of the consultation process on the White Paper for Universal Health Insurance ("UHI").

A total of 137 submissions were received from a wide variety of sources, including patient advocacy groups, private individuals, health service providers, not-for-profit organisations, private health insurance providers, academics, and others.

The Department had issued a consultation document / questionnaire intended to provide a framework for responses to the White Paper. This document set out a number of key questions for respondents to address as they set out their opinions in respect of the UHI White Paper. (A copy of the consultation document is attached at Appendix 1.)

Respondents were also free to submit responses in any format, and indeed well over half of them (62%) provided their submission as a stand-alone document, rather than using the Department's questionnaire. Of those respondents who did use the questionnaire, it is evident that many chose not to follow precisely the structure of the document and provided what amounted to a free-format submission. The breakdown of the response types is below:

Response Type	Number	%
Free-Format Submission	66	48.1%
Consultation Paper	52	38.0%
Email	13	9.5%
Letter	6	4.4%
Total	**137**	**100.0%**

The categories of respondent are set out below, with the numbers of submissions received from each group:

Categories	Number	%
Private Individuals	39	28.5%
Advocacy / Patient / Public Interest Groups	38	27.7%
Union / Representative Body	20	14.6%
Educational / Research Sector / Academia	16	11.7%
Health Service Organisations	10	7.3%
Health Insurers	4	2.9%
Pharmaceutical Companies	3	2.2%
Government Departments	3	2.2%
Regulatory Bodies	3	2.2%
Political Parties	1	0.7%
Total	137	100.0%

Some subcategories were created for some of these groups: "Personal" respondents in some cases had specific attributes, e.g. working as health professionals, that meant their submissions were not easily grouped with those submitting in a "lay" individual capacity. Similarly, a number of academics made submissions clearly setting out their academic institution and their credentials, whilst still

technically submitting in a personal capacity as opposed to as a representative of the institution in question. In the case of the former, the table below sets out the subcategories assigned to the Private Individual submissions. In the case of the latter, such submissions are grouped within the "Educational / Research Sector / Academia" category, noting that 5 of the 16 in this category identified their submissions as personal.

Private Individuals Subcategories	Number
Personal	23
Health professionals	12
Academic	1
Consumer information	1
Health Insurance	1
Health Researcher	1
Total	**39**

Because of the lack of uniformity in the submissions, and the diverse nature and presentation of the opinions offered, it is not possible for us to present any quantitative statistics in relation to the consultation process. However, the themes which appear most often within the submissions may be summarised as follows:

- overall, there is a substantial demand for fairness within the health system, specifically with regard to the allocation of resources and people's access to services;
- there is a broad welcome for the Government's aim and intention to reform the health services to bring about a single-tier health system with equity of access, i.e. universal health care. There is also some limited support, from private health insurers in particular, for implementing an insurance-based structure to support this aim. However, there is a clear demand for greater clarity and more detail on how UHI might be implemented – often, those who have indicated general support for the concept of UHI have been reluctant to go further, citing a lack of clarity on how UHI would work in practice.
- by contrast, many other respondents have indicated that they oppose UHI in principle, or the specific UHI model proposed within the White Paper, often on the grounds that they see it as another form of indirect taxation which will prove costly to the people of Ireland; because they believe that it will lead to the continuation of a two-tier health system; and/or because the particular model put forward on the basis of competing insurers does not represent, in their opinion, the best option for the reform of the health service;
- many of those who responded have commented on the Dutch model upon which the proposed Irish UHI model is based, and a frequently-expressed concern is that insufficient attention was given to other possible models from elsewhere, with some respondents also suggesting that the Dutch model has proven to be problematic in the Netherlands in relation to, for example, rising costs, so that it may not be well suited to the needs of the Irish health care system;
- a significant number of people have referred to the potential for UHI to become very bureaucratic and complex to administer, resulting in additional costs to the State;
- concerns have also been expressed by a number of respondents relating to potential threat to the private health insurance market in advance of the introduction of UHI, and also to the implications for those holding private health insurance policies;
- many respondents have also indicated their concern regarding the impact of UHI on individual patients and families, including those currently holding medical cards or availing of the Long-Term Illness Scheme, Drugs Payment Scheme, and similar; those requiring specialist high cost treatments or medicines; and those whose care involves integrated pathways across a range of treatment types.

19 themes were identified during the analysis of the 137 submissions, and they form the basis for the content of this report. In summary, the 19 themes are as follows:

A. **Timetable for the Proposed Reforms** – The proposed introduction of universal health insurance by 2019
B. **Debate re UHI vs. Other Funding Structures** – Whether the White Paper-proposed UHI structure for the future funding of the health services represents the best option
C. **Costs – to Individuals/ Households and to State** – The potential costs of the UHI system, from the perspective of those paying into the system, and from the perspective of the Exchequer costs that it will entail
D. **Implications for Private Health Insurance Policyholders and Others in respect of the Compulsory Nature of UHI** – The concern from various perspectives that the perceived elements of choice in relation to taking out private health insurance and key benefits thereof (e.g. rapid access to healthcare), will be lost under the proposed UHI system
E. **Medical Cards and Other Entitlements** – Concern regarding the potential changes to entitlements for those with medical cards and/or covered by other schemes such as the Long-Term Illness Scheme and the Drugs Payment Scheme
F. **Drugs/Medicines Costs, Cover, and Eligibility** – How and where the costs of drugs/medicines fit into the basket of UHI provision, and, if some medicines will not be covered by UHI, who will pay
G. **Capacity in Current System** – The ability of the current health system resources and structures to undertake the proposed changes under UHI
H. **Threat to PHI Market in Advance of UHI** – Concerns regarding the potentially destabilising effect the imminent introduction of UHI could have on the private health insurance market in the period leading up to UHI
I. **Dutch Model Proving Problematic** – The UHI structures in the White Paper are modelled on the Dutch system, which is experiencing increasing challenges in terms of cost and other issues
J. **Lack of Clarity** – Lack of clarity and definition within the White Paper in respect of the proposed reforms, their implementation and operation
K. **Bureaucracy/Administrative Burden** – The perceived bureaucracy and administrative burden within the UHI structures proposed
L. **Complexity** – The proposed structures and funding systems appear very complex
M. **Two-Tier System Continued** – UHI as envisaged in the White Paper may still comprise a system where supplementary insurance means that those on higher incomes may be able to access more
N. **Defining which Health Services Are Funded by which Source** – Some health services will be funded by UHI and some directly; there may also be others for which supplementary insurance will pay
O. **New Tax by Another Name** – The introduction of compulsory UHI means that individuals and families will be paying additional amounts for what is currently paid out of taxation revenue
P. **Potential Influence of Insurers on Healthcare Decisions** – Concern that medical decisions may be driven by health insurers rather than based solely on the best interest of the patient
Q. **Community and Continuing Care** – The role of community and continuing care in the health system as envisaged by the White Paper
R. **UHI May Not Support Integrated Care Pathways** – The proposed funding structures may hinder smooth transitions between various forms of care
S. **Role of Not-for-Profit Organisations** – Some health and social care in Ireland is delivered by the not-for-profit sector; the future integration of this care and the funding thereof is not clear in the White Paper

A rich body of material has been provided by respondents in their consultation submissions following the White Paper, and a large number of contributors have expressed their hopes that their views and opinions will be taken into account by the Department and the Minister as the UHI policy is further developed.

1 Introduction

1.1 Background

Crowe Horwath was commissioned in July 2014 by the Department of Health ("the Department") to undertake a thematic analysis of submissions received as part of the consultation process on the White Paper for Universal Health Insurance ("UHI").

1.2 Terms of Reference and Key Deliverables

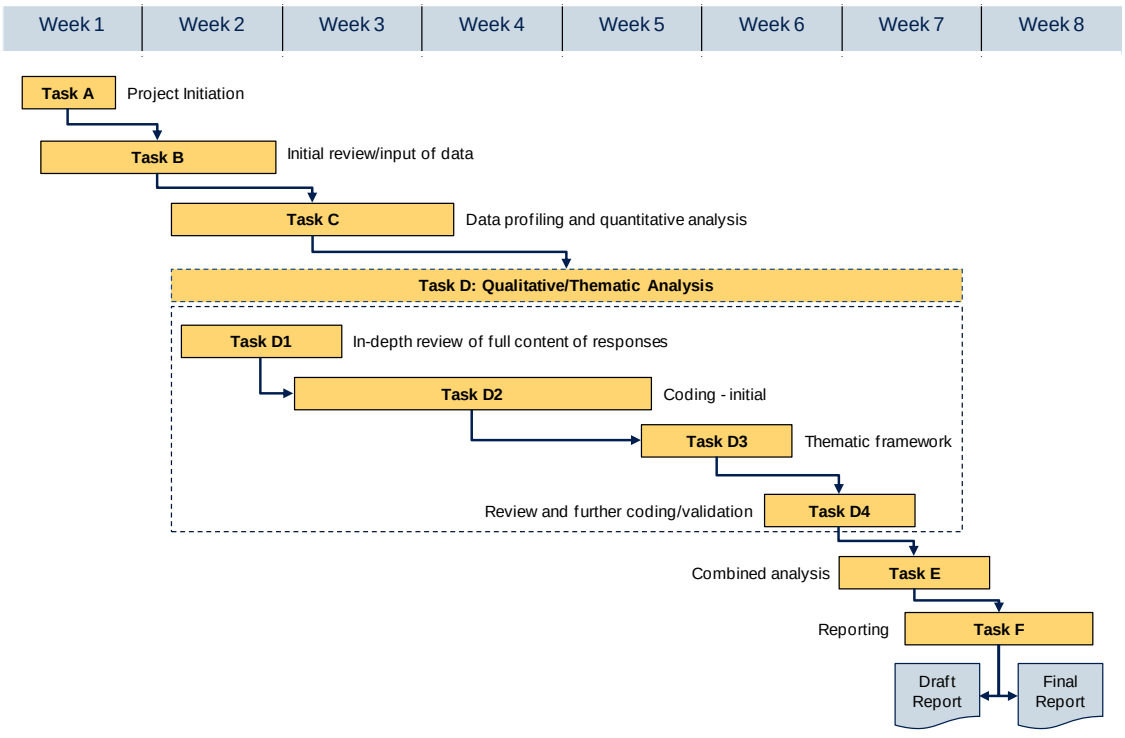
The terms of reference set out by the Department for this assignment[1] were to conduct a thematic analysis of all submissions made in response to the call for submissions on the White Paper on Universal Health Insurance. The specific objectives were for the consultants/researchers to produce and provide to the Department:

a) A database collating the views from the responses to the call for submission according to questions posed in the consultation document and additional views and comments (e.g. where respondents have availed of the option not to use the consultation document).[2]

b) A report 'Analysis of submissions made on the White Paper on Universal Health Insurance' providing a thematic analysis of submissions received.

1.3 Approach to this Study

We set out a proposed methodology in our tender to the Department for undertaking the assignment, illustrated below:



1 This assignment was commissioned by issuing a request for tenders document via the eTenders website outlining the terms of reference and specification for the project.

2 This deliverable is being presented separately to the Department.

As can be seen, the approach encompassed the following tasks:

A. Project initiation: formal initiation of the project with the Department representatives overseeing the assignment;

B. Initial review/input of data: high-level review of the submissions received, to get an initial sense of the nature and content;

C. Profile and quantitative analysis: extracting from the submissions the profiling information that tells us about those responding;

D. Thematic analysis: this task had a number of sub-tasks: in-depth review of submissions; initial coding; thematic framework development; and review and further coding/validation.

E. Combined analysis: bringing together the various strands of activity;

F. Reporting and sign-off: the development and delivery of draft and final reports for Departmental approval.

1.4 Structure of the Report

The report is structured as follows:

Section	Content
Report Highlights	One-page summary of high-level findings
Executive Summary	Summary of key findings of the study
1. Introduction	Introduction and terms of reference
2. Profile Submissions	Overview of the types of submission received and the categories of those who responded
3. Thematic Analysis	The main findings from the analysis of the content of the submissions received
4. Concluding Comments	Our final comments on the process and findings

2 Profile of Submissions

2.1 Overview of Submissions

A total of 137 submissions were received from a wide variety of sources, including patient advocacy groups, private individuals, health service providers, not-for-profit organisations, private health insurance providers, academics, and others. Crowe Horwath undertook an initial review of the submissions to determine the nature of the material submitted and the respondent types, the profile of which is set out in this section.

2.2 Types of Submission

The Department had issued a consultation document / questionnaire intended to provide a framework for responses to the White Paper. This document set out a number of key questions for respondents to address as they set out their opinions in respect of the UHI White Paper. (A copy of the consultation document is attached at Appendix 1.)

Respondents were also free to submit responses in any format, and indeed well over half of them (62%) provided their submission as a stand-alone document, rather than using the Department's questionnaire. Of those respondents who did use the questionnaire, it is evident that many chose not to follow precisely the structure of the document and provided what amounted to a free-format submission within, for example, the final "Additional Comments/Observations" section. Conversely, some of the submissions that did not use the questionnaire framework did address the questions posed in the document.

It is difficult, therefore, to be precisely accurate about how many submissions were received using the consultation document framework as it was envisaged, although for the most part we counted any document submitted using the Department template as a consultation paper submission. Submissions in other formats were categorised as free-format submissions if they were in effect standalone documents, with responses in the form of letters and emails (usually short) were noted as such. The breakdown of the response types is below:

Response Type	Number	%
Free-Format Submission	66	48.1%
Consultation Paper	52	38.0%
Email	13	9.5%
Letter	6	4.4%
Total	**137**	**100.0%**

This report will also touch on some of the issues that appear to have influenced respondents' unwillingness to use the framework of the consultation document for their responses within the thematic analysis; many respondents made comments in respect of the questionnaire structure and content that indicated it did not reflect some of the issues respondents wished to address, and that some of the consultation document questions did not represent the key issues for some respondents.

2.3 Types of Respondent

The categories of respondent are set out below, with the numbers of submissions received from each group:

Categories	Number	%
Private Individuals	39	28.5%
Advocacy / Patient / Public Interest Groups	38	27.7%
Union / Representative Body	20	14.6%
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Personal	23
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Academic	1
Consumer information	1
Health Insurance	1
Health Researcher	1
Total	**39**

The "Academic" submission noted in the "Private Individual" category above is a retired academic, rather than someone currently working within a third-level institution, hence the differentiation between this submission and those grouped in the education category.

Because the numbers in each category are relatively small, especially outside the top two, private individuals (itself subcategorised into smaller numbers) and advocacy/public-interest groups, there is little merit in attempting to undertake quantitative analysis of the submissions beyond the simple profiling set out here. Where there are specific themes common to particular groups, this will be noted in the relevant discussion on the themes themselves.

3 Thematic Analysis

3.1 Preamble

The analysis was undertaken using an inductive approach, that is, a thematic framework was developed from the analysis of the content material, rather than pre-existing. The material was reviewed and summarised at a high level, and an indicative set of themes identified, before further review and analysis was used to validate and develop this thematic framework further.

Whilst all submissions were reviewed in order to develop the thematic framework, this report is not intended to be read as a summary of the content of all submissions. Rather it is intended to set out those themes emerging from this material that would be regarded as particularly pertinent, common to many respondents, and/or of specific relevance to the proposals for the implementation of universal health insurance as envisaged in the White Paper.

Mindful of the sensitivity of the material contained within the submissions, the highest levels of confidentiality and data protection were maintained. Crowe Horwath signed a non-disclosure agreement as part of the contract with the Department before having sight of any of the submissions, and the material has been handled in confidence throughout the process.

This report includes direct quotations extracted from many of the submissions received alongside summary analysis of themes and opinions expressed in the consultation process; however, no individual sentiment or quotation is attributed to any one respondent and any identifying material has been redacted where appropriate. It should also be noted that we have included quotations on a *verbatim* basis, to preserve the integrity of the submissions as received, including the respondent's original punctuation, spelling and grammar.

The findings are presented as follows:

- a visual representation overview of the key themes;
- a summary list of the themes and the emerging findings from the analysis;
- a subsequent discussion of each of these, including:
  - the ways in which respondents addressed them;
  - illustrative extracts from the submissions themselves;
  - the inter-relationships between themes.

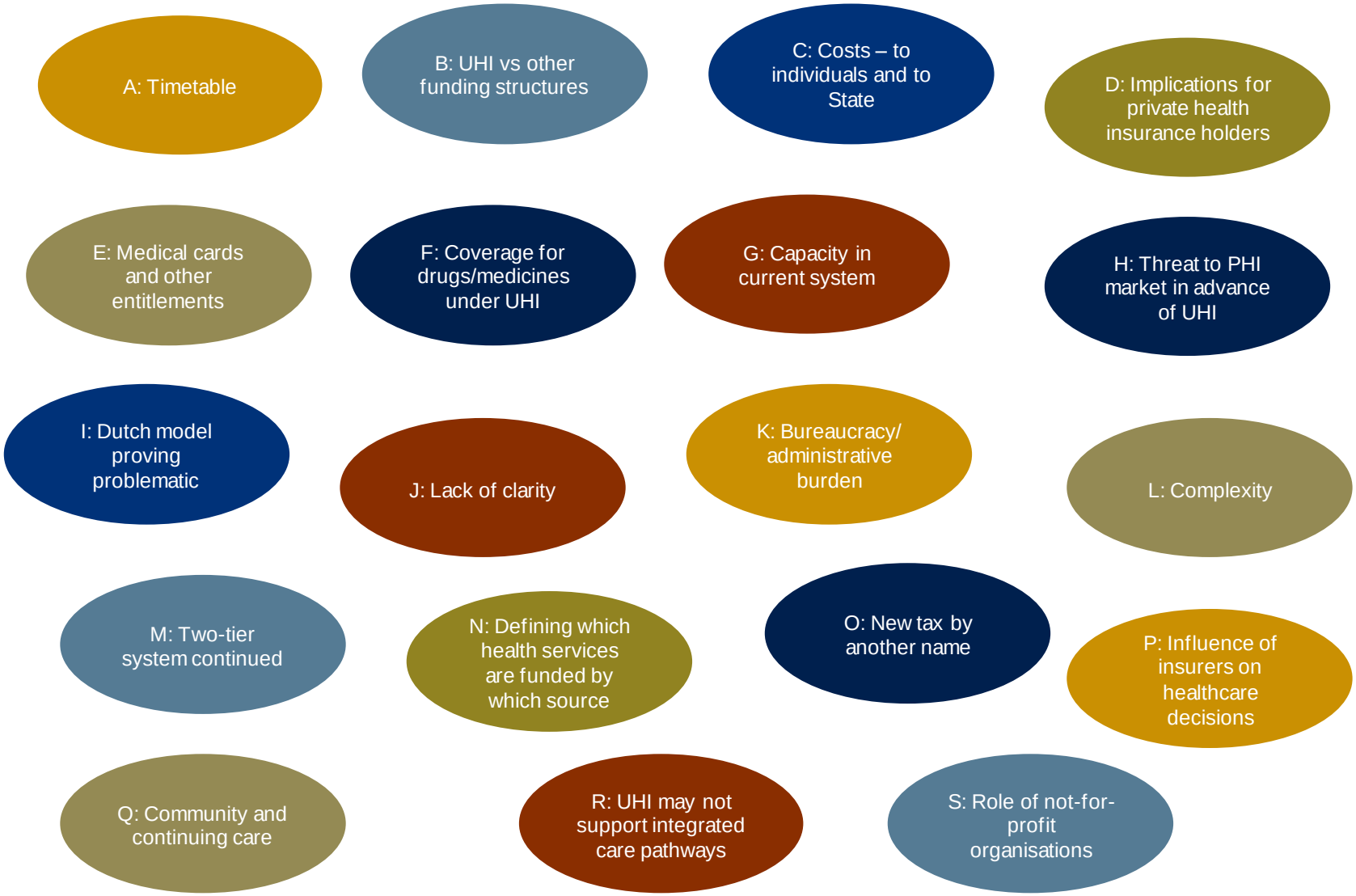
3.2 Overview of Key Themes

3.2.1 Introduction

The principal themes emerging from the review of the submissions to the White Paper are illustrated graphically overleaf, and a brief description of what these headline themes relate to is set out in the subsequent table.

The representation of the themes overleaf is in no particular order, and no relationships are identified therein. It is intended to give an easy-to-understand overview of the kinds of issues considered important by the respondents to the consultation process.

Thematic Framework for UHI White Paper Submissions



3.2.2 Summary of Key Themes Arising from Thematic Analysis

Theme		Summary of Emerging Findings from Analysis
A	Timetable for the Proposed Reforms	The proposed introduction of universal health insurance by 2019
B	Debate re UHI vs. Other Funding Structures	Whether the White Paper-proposed UHI structure for the future funding of the health services represents the best option
C	Costs – to Individuals/ Households and to State	The potential costs of the UHI system, from the perspective of those paying into the system, and from the perspective of the Exchequer costs that it will entail
D	Implications for Private Health Insurance Policyholders and Others in respect of the Compulsory Nature of UHI	The concern from various perspectives that the perceived elements of choice in relation to taking out private health insurance and key benefits thereof (e.g. rapid access to healthcare), will be lost under the proposed UHI system
E	Medical Cards and Other Entitlements	Concern regarding the potential changes to entitlements for those with medical cards and/or covered by other schemes such as the Long-Term Illness Scheme and the Drugs Payment Scheme
F	Drugs/Medicines Costs, Cover, and Eligibility	How and where the costs of drugs/medicines fit into the basket of UHI provision, and, if some medicines will not be covered by UHI, who will pay
G	Capacity in Current System	The ability of the current health system resources and structures to undertake the proposed changes under UHI
H	Threat to PHI Market in Advance of UHI	Concern regarding the potentially destabilising effect the imminent introduction of UHI could have on the private health insurance market in the period leading up to UHI
I	Dutch Model Proving Problematic	The UHI structures in the White Paper are modelled on the Dutch system, which is experiencing increasing challenges in terms of cost and other issues
J	Lack of Clarity	Lack of clarity and definition within the White Paper in respect of the proposed reforms, their implementation and operation
K	Bureaucracy/Administrative Burden	The perceived bureaucracy and administrative burden within the UHI structures proposed
L	Complexity	The proposed structures and funding systems appear very complex
M	Two-Tier System Continued	UHI as envisaged in the White Paper may still comprise a system where supplementary insurance means that those on higher incomes may be able to access more
N	Defining which Health Services Are Funded by which Source	Some health services will be funded by UHI and some directly; there may also be others for which supplementary insurance will pay
O	New Tax by Another Name	The introduction of compulsory UHI means that individuals and families will be paying additional amounts for what is currently paid out of taxation revenue
P	Potential Influence of Insurers on Healthcare Decisions	Concern that medical decisions may be driven by health insurers rather than based solely on the best interest of the patient
Q	Community and Continuing Care	The role of community and continuing care in the health system as envisaged by the White Paper
R	UHI May Not Support Integrated Care Pathways	The proposed funding structures may hinder smooth transitions between various forms of care
S	Role of Not-for-Profit Organisations	Some health and social care in Ireland is delivered by the not-for-profit sector; the future integration of this care and the funding thereof is not clear in the White Paper

3.3 Key Themes

3.3.1 Overview

As outlined in Section 3.1 above, this section sets out the main findings arising from the in-depth analysis of the submissions received as part of the consultation process on the White Paper on Universal Health Insurance. This section sets out each of these principal themes (as listed and illustrated in Section 3.2), with definitions of what is intended to be understood by the theme titles, descriptions of the broad thrust of the issues, the ways in which respondents addressed them, and the inter-relationships between different themes. This material is illustrated with extracts from the submissions themselves (none, as discussed above, attributed or identifiable as originating with any individual respondent). Such extracts, direct and verbatim quotations from the text contained in the relevant submissions, is highlighted as follows:

> *"Sample illustrative quote from submission."*

It should be noted that as the quotes are taken verbatim, other than noted ellipses and so forth, all text is as it appeared within the submissions themselves, and is reproduced without amending spelling or grammar.

3.3.2 Theme A: Timetable for the Proposed Reforms

Theme A: the proposed introduction of universal health insurance by 2019

The White Paper set out the proposed timetable for the phased introduction of UHI, intended to be fully implemented by 2019. This timetable was considered by some respondents to be too ambitious and unrealistic.

> *"It is too much, too soon."*

> *"The plan…has an unrealistic timeframe."*

Some were concerned that the timeframe presented risks to the successful implementation of the new structures:

> *"There is a significant concern that the five year implementation period included in the White Paper is too short."*

It was also suggested by some respondents that continuing on the proposed timetable might jeopardise the quality of the new health system.

> *"The most important priority in my view is to slow the entire process down. Trying to achieve all that is planned by 2019 is not realistic and risks making mistakes in the interest of expeditiousness."*

> *"It is planned to develop quickly a wide range of new capacity, structures, systems and skills which will inevitably fail to some extent, and a much safer route to the same destination will be less disruptive, slower, and developmental and will build on what is best in the current arrangements."*

"The limited timetable being considered to implement the proposed changes is a major concern because it significantly increases the risk that the delivery of acute hospital and mental health care, required by an increasing number of patients, will be adversely impacted and potentially undermined."

This theme is related to others as follows:

- strongly related to the issue of the **capacity within the current healthcare system**, with many concerned that the latter would mean that the timetable could not be adhered to without substantial and immediate investment in resourcing various aspects of the healthcare system;
- the **debate on UHI vs. other funding structures** is also relevant, as some feel that the timetable for UHI should be extended to allow for consideration of alternative or revised funding structures;
- the issue around the **threat to the PHI market in advance of UHI** is directly related to the timeframe for the implementation of UHI;
- the theme of **complexity** also interrelates to the timetable for the introduction of UHI, because the perceived complexity of the proposed structures

3.3.3 Theme B: Debate Regarding UHI vs. Other Funding Structures

Theme B: whether the White Paper-proposed UHI structure for the future funding of the health services represents the best option

Universal Healthcare versus UHI

The White Paper sets out the objective of the proposed reforms as follows: "to develop an efficient and effective single-tier health service which promotes equitable access to high quality care on the basis of need". Many participants state that they fully support such an objective.

"We welcome wholeheartedly the stated intent in the Programme for Government to develop a single tier health service seeking to end the current unfair, unequal and inefficient two tier health system."

However, a significant number of respondents draw a distinction between "universal health care" – their interpretation of the foregoing objective – and the funding model the White Paper proposes to deliver this, "universal health insurance".

"[We] welcome the introduction of a single tier health system which promotes equitable access to high quality care on the basis of need, not ability to pay, and support the core aim to make health services fairer and more efficient. However, [we] question the fundamental proposals underpinning Governments introduction of Universal Health Insurance (UHI), with our concerns hinged on how the system will be implemented rather than on the principle itself."

Respondents indicated that they agreed with the principle of establishing a fairer, more equitable health system, but expressed concerns that the specific model of universal health insurance proposed in the White Paper was not necessarily the only mechanism to deliver this:

"…fully aligned with the proposal within the White Paper of 'ending the unfair, unequal and inefficient two-tier health system and to introducing a single-tier system'…these objectives as set out in this paper and the speed at which they propose to achieve them which may not, in the long run, be the optimal manner in which these excellent aspirations can be achieved."

"This aim is an important one, but it has not been established that the proposed system (which involves a number of competing insurers) will succeed in achieving the necessary improvements in equity, quality and efficiency."

One response pointed out that a reformed funding model would not in itself deliver universal healthcare:

"However, we recognise that merely changing the way the health system is financed, or care is purchased will not of itself ensure universal access to health care."

Restrictions in Consultation Process

A number of respondents mentioned that, in their opinion, the consultation process was flawed because it was based on the specific model of UHI proposed in the White Paper, rather than inviting discussion or debate as to whether this represents the only or the best option for the future structures and resourcing of our healthcare system.

"The White Paper, as published, presupposes that an insurance based system is what should be used when instead all options for health care funding should have been included."

There were comments from participants to the effect that such significant and far-reaching reforms were not openly debated ahead of selecting the proposed UHI model, given their importance and impact on healthcare delivery, costs, resources, and so forth. A number of respondents were unhappy that these aspects, perceived to be of significant national importance, were not part of the consultation process.

"We do not agree with this model and question why alternative options were not offered for consultation and debate given that this is the most fundamental reform of the Irish health system ever undertaken."

"A debate should occur on what mechanism of UHC would best suit the Irish context."

Alternative Funding Models

The selection of the multi-payer competitive insurance model was debated by a number of participants, with several suggesting that alternative models, such as direct taxation funding for all healthcare or single-payer social insurance structures, should still be under consideration and open for debate.

"It is imperative that a consultation process at a minimum involves a discussion and analysis of the three main systems that can deliver UHC [universal health care]. By avoiding a discussion on both single-payer models and tax-funded / public service systems, the credibility of this public consultation process has been fundamentally compromised."

"There are good reasons to question the chosen model of UHI, and it is likely that it would lead to avoidable costs and unnecessary complexity."

Respondents in some cases call for a further process of consultation and debate, informed by the Government's own findings as referenced in the White Paper, on the model of healthcare delivery and funding most suited to the Irish context.

"The Government should clearly set out the reasons why the selected model best fits Irish needs and its advantages over alternative models, including other multi-payer and single fund models. By having this debate now, ongoing recrimination over the method of reform can be avoided in the run-up to implementation… there should be a national discussion, informed by greater access to relevant information, about the kind of healthcare system we want in Ireland and what policy mechanism should be used to achieve this."

Competition

Many of the opinions expressed within the submissions related to the issue of how a competitive UHI system would operate. Some felt that competition would be detrimental to the healthcare system overall, in particular in a small country such as Ireland.

"This model of multiple competitive health insurance companies ensuring health cost reductions has been proven flawed in its application in some countries, most recently, the Netherlands. It was estimated that the minimum population required to ensure competition was 8 million. "

"The extent to which competition among insurers is viable in an UHI market based on the population in Ireland. It would be better to have a single state run operator subject to rigid costs controls than multiple insurers, driving up costs and fundamentally not being sustainable."

"It is unlikely Ireland will attract enough insurers to the market to allow for effective competition. The recent introduction of a six-hospital group model may similarly hamper a successful introduction of a UHI system. How can there be adequate competition between providers with just six hospital trusts?"

Private health insurers indicate a desire to see a very open and competitive market, with considerable freedom in terms of contracting with providers.

"Competition should be based not only on price but on the quality of care, length of stay and outcomes provided to patients."

"We would also stress that the services of private and public providers should be integrated to facilitate full competition. Insurers should be able to contract based upon the quality of the services provided and should be allowed to discriminate based on a provider's level of expertise and specialism."

Health insurers and other respondents also observed that the proposed cost-control regulatory mechanisms within the White Paper include capping of profits and overheads of insurers; these proposals were cited by a number of submissions, in particular from the private health insurance sector, as counter to the principle of open competition in the market.

"Regulation is not conducive to competition."

"We believe some of the mechanisms identified in the White Paper to manage costs amount to a disproportionate use of regulation which will stifle competition."

Some additional discussion on the opinion in relation to the profit-caps and cost control measures for insurers is set out in Section 3.4.3, within the text on regulation.

This theme relates to a number of others, including:

- **capacity in the current system**: some question whether the significant changes in structures and the associated resources that will be required to deliver the reforms will be an excessive strain on the current healthcare systems;
- **costs**: those who question the appropriateness of the UHI model set out in the White Paper highlight the potential costs associated with multi-payer models;
- **Dutch model**: the model being used as a template for the UHI reforms is that operating in the Netherlands; evidence is emerging of problems relating to costs and operation of the system in question, leading many to question whether this is now an appropriate model for Ireland to implement and whether alternatives should be debated.

3.3.4 Theme C: Costs – to Individuals/Households and to State

Theme C: the potential costs of the UHI system, from the perspective of those paying into the system, and from the perspective of the Exchequer costs that it will entail

Uncertainty

Respondents expressed concerns regarding the lack of information relating to the ultimate costs of the proposed reforms in the White Paper. Some commented that this dearth of definitive information in relation to costs made it difficult to assess the feasibility of introducing the proposed UHI system. The concerns expressed related to the lack of data in respect of a number of aspects:

- the costs of implementing the reforms themselves, i.e. the costs of setting up the UHI system;
- the cost of operating the system once implemented;
- the potential cost to individuals/households in terms of their UHI premium payments.

"…concerned that the White Paper omits or defers the provision of information on core elements of the proposed new system including…the estimated costs of UHI for individuals, business and the state."

"The lack of any data on costs of the proposed new system is a major deficit which needs to be addressed before coming to a view on the feasibility of introducing the proposed system."

Costs Relating to Reform Process

A number of respondents commented on their concern at the potential costs for the establishment of the proposed UHI structures, and expressed doubt as to whether the benefits of the move to UHI would outweigh the costs of reform.

"The funding model proposed for the new system may be unduly complex and costly to deliver."

"Implementation of UHI will undoubtedly require substantial investment and financial resources…Such a massive change cannot be done without an associated cost, and this must be acknowledged."

Respondents expressed disquiet at the apparent lack of additional resources earmarked to cover the anticipated substantial costs of the proposed reforms, in one case set against the example of the recent establishment of Irish Water as part of the reform of water management in the State:

"The Department appears to have no budget available to establish the UHI system and total spending will not increase in the initial set-up phase (including administrative costs, research, design and set-up of the new system). The lack of set-up funding for health reform can be compared with the reported €180 million provided for the establishment of Irish Water…The costs of introducing health reform should be assessed and a reasonable set-up budget set aside."

Costs Relating to the Operation of the UHI System

Additionally, respondents were apprehensive about the ongoing costs of operating the proposed new structures and delivery of health services. Some linked this to the evidence emerging from the Netherlands and elsewhere about rising costs within UHI systems:

"UHI based on competing commercial insurers has failed to deliver cheaper healthcare costs with greater access for all in countries where it has been adopted."

"UHI systems are typically more expensive than other universal systems."

"It is inevitable that the proposed structures and processes would substantially increase transaction costs."

(Further discussion on respondents' opinion in respect of the Dutch model of UHI is set out in Theme I.)

One participant doubted the capacity of the proposed reforms, based on the information provided, to reduce costs from those in the current system:

"It is not evident from reading The White Paper that the high administrative costs of the current system resulting from the myriad layers of entitlements, thresholds to entitlements, payments and co-payments, and discretionary entitlements will be reduced let alone eliminated."

Again, the issue of lack of clarity and uncertainty is of concern to respondents in relation to the ongoing costs; participants frequently commented that there was little hard data in relation to the projected costs of operating the UHI-based health system, and that such information was required to be made public.

"Much greater clarity is required about the annual cost of the UHI system to the State and to individuals."

Concern was also expressed by respondents in relation to the projections within the White Paper for healthcare costs to remain relatively stable and for health promotion and population health measure to drive down the requirement for and consequent costs of treatment.

"There is a worrying trend in the White Paper to overemphasise the ability of preventive and proactive care to reduce disease burden and costs. Too much emphasis on proactive care will significantly drive up costs."

Cost of UHI to Individuals/Households

Participants also had a number of questions and concerns surrounding the potential cost of UHI to individuals and households, in terms of "standard" premiums, the level of financial subsidy for those on low incomes, the thresholds for such subsidies, the possibility of supplementary insurance requirements to access particular services, co-payments and out-of-pocket expenses, and the potential for UHI to cost individuals and households more as time goes on.

The concern from respondents around the costs to the individual/household is fuelled by reports of rising premium costs in the Netherlands, and there is considerable disquiet about the potential for costs to rise in relation to what individuals and families will be required to pay.

"In the Netherlands UHI premiums are increasing, and insurance companies have reported losses on basic policies."

One respondent indicated that they were:

"…concerned at the very real risk of an upward only price structure which would be impossible to finance for those on insecure incomes."

The lack of information in respect of the proposed subsidy to those on low incomes was also criticised by respondents, who have concerns about what thresholds at which such subsidy will operate, what those on low incomes may have to pay, and whether they will have any restrictions on access to certain services.

"No data is provided on how many will be subsidised, or the income thresholds."

"There are no figures provided for the cut-off thresholds and this uncertainty is problematic for continuity of care."

This is exacerbated in the opinion of some respondents by the allusion in the White Paper to supplementary insurance, out-of-pocket payments, and co-payments, on which there is perceived by respondents to be little detail and about which they have concern regarding the eventual total cost of access to all healthcare services to the individual or household.

"The role of supplementary insurance will result in some people paying additional monies for additional services and this, in our view, is clearly incompatible with equal access based on need rather than financial ability."

"Services omitted from the basket…will have to be funded by way of supplementary payments by patients themselves , in addition to their compulsory UHI payment."

Some responses question the use and purpose of co-payments within a system intended to ensure equity of access:

"Large co-payments defeat the objective of UHI and suggest need to revise premia."

"Any rise in the frequency and level of co-payments decreases the equity of the system as co-payments are, by nature, excluded from the basket of services."

The cost theme is related to many of the other themes, in particular:

- it is strongly related to the issue around the **lack of clarity** in the White Paper on many details of the proposed reforms, as lack of detail and guidance on the costs to the individuals/households and the Exchequer is of concern to respondents;
- much of the concern around **costs** stems from the experience of the Dutch model, the evidence from which was cited by respondents as indicative of future cost issues for the Irish UHI proposals;
- the issue around **defining which health and social care services will be funded by which mechanism** is closely associated with concerns over how services will be funded by the State and how much individuals will be paying for access to particular services;
- the **debate as to whether UHI as envisaged in the White Paper represents the best option** for the future structure and delivery of healthcare is associated with the anticipated costs for the various alternative mechanisms suggested by respondents;
- the issue of **capacity in the current system** has cost implications if such capacity requires to be increased with consequent additional costs.

3.3.5 Theme D: Implications for Private Health Insurance Policyholders and Others in respect of the Compulsory Nature of UHI

Theme D: the concern from various perspectives that the perceived elements of choice in relation to taking out private health insurance and key benefits thereof (e.g. rapid access to healthcare), will be lost under the proposed UHI system

Choice

Participants noted that the introduction of the proposed universal health insurance system would remove the element of the choice as to whether to pay for health insurance:

"I am alarmed that I will be required to maintain this level of payment to effectively become a 'public' patient."

"The individual has a choice and has the power to select or reject private health care provision…the requirement for universal health insurance will disempower the individual and patient."

"UHI is, in effect, private health insurance, imposed on the Irish people and denying them freedom of choice as to their preferred health insurance options."

This issue is a concern to some respondents in respect of the cohort of people who do not currently choose, many by reason of affordability, to pay private health insurance premiums. Some participants believe that this removes this element of choice from such individuals:

"This scheme does away with the freedom of choice as we have at present, ok it might not be a perfect choice at present but at least it gives a choice to Irish people."

> *"By far the biggest cost burden would fall on individuals and families who do not currently have private health insurance and who do not qualify for medical cards. Given the fact that private insurance delivers better access to health services, it is safe to assume that most people in this category simply cannot afford private health insurance. Yet they will be required by law to pay for private insurance for every family member."*

> *"Thus the individual has a choice and has the power to select or reject private health care provision. In contrast to the existing situation, the requirement for universal health insurance will disempower the individual and patient."*

Loss of Principal Benefits

A key and repeated concern stated within the submissions of those responding to the consultation process was the perception that the introduction of UHI will mean that those currently paying private health insurance premiums will continue to pay what will then be UHI premiums, potentially at similar cost to current private health insurance policies, but will lose one of the perceived principal benefits currently offered by private health insurance, that of faster access to healthcare. Respondents appear concerned that the reforms will not deliver a system that improves access to care for all by comparison with the current public health system.

> *"Access is undoubtedly the primary reason why 50% of the population currently purchase health insurance on a voluntary basis."*[3]

> *"To address the issue of <u>some</u> patients waiting longer for access to services with the solution being that instead <u>all</u> will wait longer for access to services seems counter-productive."*

There is concern among respondents that those paying for private health insurance now will pay UHI for what may constitute a lesser service, in particular in terms of the perceived ability to access care in a timely fashion, but also the choices perceived by respondents to be offered by private health insurance in terms of choice of healthcare provider (both in relation to institution and consultant) and in terms of choice of accommodation (lower-occupancy rooms).

> *"When UHI is introduced at that time everyone will have equal access to a system with a still significant segmentation in setting, which will give rise to considerable tensions between the providers, the insurers and the ultimate customers who will naturally want the best setting available."*

> *"Access must be one of the key metrics of the success of any health insurance contract. If it is not then the new system will simply move the delays long associated with the public system into the insurance sector."*

> *"Everyone would prefer to be treated in a private room in a private hospital rather than in a public ward in a hospital trust."*

It is also clear that many respondents regard the current system as conferring unfair advantage on those who can afford private health insurance, and who consider that any reforms should address this disparity of access:

[3] Verbatim quote from respondent; the actual figure for those holding private health insurance policies as at end June is 44% as per the Health Insurance Authority August Newsletter: www.hia.ie/assets/files/Newsletters/HIA_Aug_Newsletter_2014.pdf

"The first priority of any reform, must be to eliminate the ability of private patients to jump the queues in public hospitals."

Addressing Public Concern

Some respondents question how this will be "sold" to the public, in that it will be challenging for the Government to persuade such a large group of people that there is any benefit in implementing a system that entails them paying similar health insurance premiums for access to what will in effect be akin to the current public healthcare system, with no perceived advantage in terms of faster access or choice of healthcare provider.

"The proposed UHI system is intended to make [those accessing the public healthcare system] pay for something that they now get free, and to deprive [private health insurance customers] of the principal benefit they now enjoy. This does not sound like a vote-winner to me."

"Those who have health insurance say they will be paying for a lesser service and that the government will be intervening in their contract with their insurer. Further that they will have to wait longer for a service."

It is related to other themes, including:

- the issue of supplementary insurance continuing to perpetuate some elements of the current two-tier system (will those paying private health insurance now have to pay even more to retain even some of the current benefits?);
- the perception that UHI premiums will be merely additional taxes by another name (continuing to pay insurance premiums without accruing advantages over current public health system access);
- the capacity in the current healthcare system to address the changes proposed (insufficient capacity will lead to long waiting lists, exacerbating the issue for former private health insurance customers);
- the potentially destabilising effect on the private health insurance market in the period leading up to the implementation of UHI (private health insurance customers may drop insurance).

3.3.6 Theme E: Medical Cards and Other Entitlements under New Scheme

Theme E: concern regarding the potential changes to entitlements for those holding medical cards and/or covered by other schemes such as the Long-Term Illness Scheme and Drugs Payment Scheme

Medical Cards

Respondents expressed concern at the potential impact of the proposed reforms on those who currently hold medical cards. A key concern mentioned by participants is the lack of detail in relation to what extent the current medical card and other entitlements in respect of health care will be maintained for those on medical cards, and/or whether and how much they will be required to pay under the new system.

"The introduction of UHI should not be disadvantageous for those on low incomes currently in receipt of medical cards. The State must underwrite provisions such that current entitlements to people in receipt of medical cards should be guaranteed as minimum provision under UHI."

"It will need to be made clear what a medical card will cover after the introduction of UHI, especially given the proposed introduction of a financial subsidy scheme and universal primary care."

"We also note that payments for UHI will be 'related to ability to pay' with Government paying insurance premiums for people on low incomes and subsidising premiums for people on middle incomes. The absence of detail with regard to this worries us."

As well as the issue of access to primary and secondary health services, a number of respondents noted that medical card entitlement is a proxy for access to a range of ancillary health and social care services and more, the future of which is unclear when the system is reformed:

"In addition to accessing free health services, medical card holders can also access a range of other services such as dental, optical and aural services, public health nursing, social work services and community care services as well as other non-health benefits such as paying a lower rate of Universal Social Charge, exemptions from school transport charges and state exam fees and help with buying school books. The removal of the medical card system will have far-reaching impacts on people's entitlement to many services in the community and an alternative means of determining eligibility for these services will be required."

"It remains unclear…what will happen to public community and primary care services currently only available to people with medical cards."

A concern was raised by one respondent as to the cost of maintaining such entitlements under a UHI system:

"It would be difficult to justify reducing the entitlements of those who are currently in possession of medical cards, but the cost of this could make UHI prohibitively expensive."

Long-Term Illness Scheme

Medical card entitlement was not the only statutory subsidy scheme respondents considered in terms of the potential impact of the proposed UHI system. The future of the entitlements under the current Long-Term Illness (LTI) Scheme was also mentioned by some participants:

"Existing benefits should be preserved in all instances and where possible incorporated into the new system."

"The long term illness scheme is also crucial in alleviating cost of medication for people with diabetes, epilepsy or other long term condition."

Some respondents commented that the LTI Scheme in its current format is not adequately meeting the needs of those with long-term conditions and that the future reforms should address these issues:

"These recipients should be migrated to any new system as a preliminary stage and before it is opened to new systems. It should be noted that the long term illness scheme is not fit for purpose. It covers only a limited number of chronic conditions and only covers the cost of some medications and ancillaries."

Drugs Payment Scheme

There is more discussion on the issue of cover for drugs/medicines in Theme F; however, the Drugs Payment Scheme is specifically one of the schemes with a set of entitlements the future of which respondents believe is unclear in the White Paper. Respondents expressed concerns at the future entitlements to schemes such as the DPS in the reduction of costs for individuals and households in relation to medicines.

"The Drugs Payment Scheme provides an essential limit to monthly pharmaceutical costs for a family. The White Paper seems to suggest that the Government will continue to cover the drugs costs of the lowest income group as it currently does for those on medical cards but does not commit to continuing to ensure that drug costs are affordable for everyone else."

This theme is associated with the following:

- the issue around the perceived **lack of clarity** within the White Paper extends to this theme, as respondents felt that there was insufficient detail on the future entitlements of those on medical cards or other schemes;
- the scheme that caps the amount payable for prescription medicines, the Drugs Payment Scheme (DPS), was mentioned by some in the context of the theme relating to **drugs/medicines costs, cover, and eligibility**;
- the perception that **UHI will constitute an additional tax** as those currently entitled to certain services without payment may have to pay UHI to access these in future.

3.3.7 Theme F: Drugs/Medicines Costs, Cover, and Eligibility

Theme F: how and where the costs of drugs/medicines fit into the basket of UHI provision, and, if some medicines will not be covered by UHI, who will pay

A number of respondents raised the issue of cover for drugs/medicines under the proposed UHI system. The question as to whether the costs of medicines should be covered within the "basket" of UHI-covered healthcare services was discussed by some participants:

The cost of drugs probably should be included in the basket

The absence of detail on this issue was noted by some respondents, who expressed a desire for more clarity on this issue in advance of the implementation of UHI.

"The White Paper leaves open the question of drugs reimbursement and how this will operate within the new UHI model. Drugs are a significant cost within health insurance and therefore the most cost efficient methodology for covering drugs must be established in advance of the introduction of UHI."

"It is noted that it has not been determined at this point if the provision of pharmaceuticals is to be included in the future health basket…it is important that the current level of access to medicines under the community drugs schemes should be preserved, whether this is through funding from the standard universal health insurance or another funding source."

Some, in their submissions, suggested that those with particular conditions would be disadvantaged unless their medication was covered under UHI:

"Those with chronic illness should not be financially disadvantaged which seems to be the outcome if only certain percentages of drugs will be covered etc."

"This is concerning for people with a disability, who often have high medical needs and drug costs and would rely on schemes like the drug payment scheme to support their payment for pharmaceuticals. This could ultimately lead to decreased health outcomes for people as they may stop taking essential medications."

As discussed elsewhere, there are concerns among respondents about the future entitlements of those currently availing of the Drugs Payment Scheme, which for some is already considered too onerous financially:

"The increase in the Drugs Payment Scheme threshold over the last number of years has resulted in many people being uncompliant with their dosage."

"For those who don't meet qualifying criteria for a medical care or long term illness, the drug payment scheme maximum of €144 per month is a significant proportion out of a single person's pension of €501, and should be reduced, as the cost of drugs does impact on compliance."

This theme is related to others as follows:

- closely associated with the concern among respondents regarding the **future entitlements under the medical card, LTI, and DPS schemes** to medicines currently available free or at limited cost;
- the lack of clarity and definition as to the **proposed cover for drugs/medicines**, in terms of who will have to pay at what level for which medicines, was noted as an issue by a number of respondents.

3.3.8 Theme G: Capacity in Current System

Theme G: the ability of the current health system resources and structures to undertake the proposed changes under UHI

Access

Many respondents highlighted their concerns that the introduction of UHI would exacerbate existing difficulties within the Irish health system, particularly in terms of access to service, lengthening waiting lists and the perceived need for investment within the public hospital system:

"The current service capacity is inadequate in places to deliver UHC."[4]

Particular concerns were raised by a number of respondents with a professional or advocacy interest in certain conditions, including Down Syndrome, Alzheimer's and Chronic Obstructive Pulmonary Disease, amongst others. These respondents noted that patients suffering from these conditions frequently experience multiple clinical problems and that accessing services is often difficult at present, not just in terms of acute hospital admissions but also with regard to diagnostic services, early intervention work, and other care within primary and community settings. A number of such respondents indicated their concern that funding for long-term care and social care should be made available under UHI, in order to provide a holistic service for patients and clients.

"At present in the public healthcare system people with Down syndrome and their families are faced with difficulty accessing services both in the clinical environment and in the community. Long delays for consultations and assessments have led to frustration, anger and upset on a regular basis. On speaking with government representatives from the Department of Health little or no assurance was provided that this would be a thing of the past with the introduction of UHI."

"Specialist services to meet the long term care needs of people with neurological conditions are very limited, and where they are in place, are primarily provided by not for profit organisations."

Resources

Whilst there was a generally positive acknowledgement by respondents of the ongoing work of the Government and HSE to rebalance the provision of care from acute hospital to primary and community settings, and to provide a more integrated model of care, concern was expressed by many respondents regarding the investment required:

"So far politicians have delivered lip service only; expecting primary care to take over chronic illnesses without any signs of resources coming."

"However, the system will need to be expanded considerably to accommodate the universal provision of nursing services in the community and to take account of the demographic changes over time."

"Integrated healthcare is a priority but at present there are major deficits in the level of care that is available in the community."

Much of the focus in these comments relates to frontline service delivery:

"There is a pressing need to ensure that increased frontline resources are provided to enable the timely delivery of healthcare services to patients."

"Whether or not Ireland introduces comprehensive health insurance there is required a very significant financial investment to meet current and future capacity constraints in the period up to 2020."

[4] As described in the Glossary prefacing this report, "UHC" or "universal health care" is used by many respondents to indicate the principle of a single-tier healthcare system with universal access on the basis of medical need rather than ability to pay.

This theme is associated with the following, among others:

- the **choice of the proposed UHI structures** as opposed to alternatives that may not present the same strain on the capacity of the current system to reform;
- the **costs** associated with the perceived requirements for investment in developing the capacity of the current system in order to implement the proposed reforms;
- **integration of care pathways under the UHI system,** given the difficulties in ensuring adequate and seamless transition between forms of care in the current system.

3.3.9 Theme H: Threat to PHI Market in Advance of UHI

Theme H: concerns regarding the potentially destabilising effect the imminent introduction of UHI could have on the private health insurance market in the period leading up to UHI

As discussed above, there is concern among some participants in relation to the potential impact on private health insurance policyholders of the introduction of mandatory UHI. This is a factor in another theme arising from the consultation process: the apprehension expressed by some respondents that the private health insurance market may be destabilised in the period leading up to the introduction of UHI.

Respondents point out that some people may decide to drop their current private health insurance cover within the two or three years in advance of the introduction of UHI, because they may perceive that they will not be disadvantaged by doing so owing to the community-rated nature of mandatory UHI as envisaged in the White Paper. As some have noted, there is already a decline in the numbers of those holding private health insurance cover, and if this continues, some believe it could threaten the successful implementation of UHI owing to the potential withdrawal from the market of health insurers.

"If health insurance premiums continue to be driven up via Government policy the numbers within the market will continue to decline."

"In addition, as it becomes certain that UHI will be introduced one of today's main motivations for people to take out PHI will vanish, namely the fear of being denied cover at some future time perhaps many years away…[this] will provide an increasingly unstable dynamic whereby the young and healthy see less and less reason to take out PHI and so the costs go up as those still contributing are at greater risk thus accelerating the dynamic. This "community rating death spiral" syndrome is already apparent as reducing tax reliefs and medical inflation have made PHI increasingly expensive but the phenomenon seems set to greatly intensify."

This theme is linked to others such as:

- the theme discussing the **perceived potential loss of benefits for those holding private health insurance**;
- the **debate as to whether the UHI system as envisaged is the best one** for the reform of the health services, with multiple insurers in the market.

3.3.10 Theme I: Dutch Model Proving Problematic

Theme I: the UHI structures in the White Paper are modelled on the Dutch system, which is experiencing increasing challenges in terms of cost and other issues

A significant number of respondents comment that the Dutch model, upon which the Irish UHI proposals are broadly based, appears to have been selected without public consultation, whereas a preferable approach would have been to examine a number of potential models and to analyse their merits and limitations before making proposals more attuned to the needs of Ireland.

Some respondents have knowledge or experience of the Dutch system, and their views are largely negative in respect of the Dutch experience, particularly in terms of price increases for consumers:

"In Ireland we need to avoid a situation that has occurred in the Netherlands where the basic insurance package is expensive and has increased in cost quite dramatically over the last number of years."

"We see that in Holland where this model was introduced in 2006 there have been year on year price increases for customers of private health insurers."

The Dutch model is also depicted within some submissions as being overly profit-driven and less capable of achieving positive clinical outcomes, with one respondent stating that:

"Lessons from the Netherlands show that this profit-driven commercial model leads to an inequitable and inefficient system of funding, different tiers of entitlement and rising hospital deficits with increased hospital re-admission rates because it creates financial incentives to discharge patients too early."

Some of the lessons from the Dutch model are perceived more favourably, however, with one advocacy group pointing out that in the Netherlands, care providers were financially incentivised to develop integrated dementia care, including case management, so that by 2011, 90% of dementia patients received integrated care. The inclusion of such initiatives was recommended by the respondent organisation.

Respondents are also concerned about implementing insurance-based healthcare services based on their perception of how such services have operated in countries other than the Netherlands, such as the US:

"The market model of health care has failed to contain overall costs in the US, where health care expenditure per capita is more than double the OECD average, and health insurance is unaffordable for many people on low income. While competition has led to innovation and some care is excellent, quality of care is not consistent and overall outcomes are poor."

This theme is associated with the following:

- concern in relation to the **costs** associated with operating a UHI-based model of healthcare services;
- the potential **continuation of a two-tier system**;
- the **debate as to whether UHI represents the optimum structure** for the funding and organisation of healthcare services.

3.3.11 Theme J: Lack of Clarity

Theme J: much about the proposed new system remains undefined and unclear

Many of the respondents indicate that whilst they may welcome the broad principles associated with universal health care, they would wish to see much more detail on the specific proposals for UHI than that which is included in the White Paper. A typical comment is this:

"There is insufficient clarity in the White Paper on the specific detailed services which will be covered by UHI. There is no detailed costing of the proposals nor have the proposals been evaluated in comparison with alternative healthcare delivery systems. The publication of the White Paper without a detailed and thorough costing severely limits any meaningful assessment of the proposals."

Many respondents expressed the view that UHI should be properly integrated with proposals for improving health and social care, with the general feeling that the White Paper fails to provide the clarity they seek in that regard.

"Equal access to treatments and medicines deemed cost-effective or recommended by the clinical programmes should be the same for all insurers."

A frequent concern expressed by respondents was that the proposed basket of services under UHI remains unclear, and there is no definition included within the White Paper regarding the principles by which services in the basket will be selected for inclusion within the package. One respondent, an advocacy organisation within the intellectual disability sector, drew attention to the position of

"…essential services such as physiotherapy, speech and language therapy and occupational therapies."

They queried whether or not these services would be included in the basket of services, also adding that they

"…would like confirmation of the persons who will be involved in deciding what services will be covered under the new proposed system."

This respondent noted their concern that a lack of knowledge about intellectual disability generally, and the specific condition that their organisation represents, might result in the main focus being on cost rather than specific client needs. This concern was echoed by a number of patient advocacy and representative organisations: that a lack of specialist knowledge or complete understanding of the nature, complexity, and comprehensive health and social care needs of those with particular conditions and/or disabilities would result in the implementation of reforms that would potentially compromise their care.

The financial impact upon individual families is also noted by a number of respondents, with concern expressed that it is difficult to assess UHI proposals as the White Paper does not contain any information on the cost to individuals and whether any changes to current PRSI will follow its introduction. One respondent notes that whilst persons with medical cards will be subsidised further under UHI, they would like more clarity on the amount that will be covered and on how additional costs (i.e. above and beyond what may be covered by UHI) might be managed by those who are not in receipt of an income.

This theme is associated with the following:

- the **lack of detail** surrounding the anticipated costs of the implementation and operation of the UHI system to the individual/household and the State;
- the absence of information on precisely **which services will be funded by which mechanism**, i.e. within the UHI basket, directly funded by the Exchequer, or covered partly or fully by supplementary insurance and/or co-payments;
- the lack of information regarding the **cover for drugs/medicines** and the eligibility associated with such cover.

3.3.12 Theme K: Bureaucracy and Administrative Burden

Theme K: the perceived administrative burden within the UHI structures proposed

Respondents have misgivings in relation to their perception that the proposed structures under UHI as set out in the White Paper appear to entail a significant number of new and reformed agencies and organisations to operate and manage the system. Concerns were expressed by participants in respect of the number, complexity, and cost of these bodies.

"However, the need for a variety of existing agencies and proposed new bureaucracies with their associated costs should be re-examined."

"We also have concerns regarding the plans to establish several agencies related to the establishment of UHI, commissioning, patient safety etc., these costs will be deducted from the overall total health budget."

The potential difficulties associated with having a large number of different agencies involved in the management, funding, and delivery of healthcare services, such as communication and duplication issues, were highlighted by some.

"…possibly leading to a multiplicity of agencies which will need to communicate and be consistent in their approaches."

Some also pointed out the potential cost of the multiplicity of bodies envisaged under the new system, including multiple insurers and providers as well as the statutory agencies, and note that such cost will be built into the costs of operating the proposed UHI structures.

"The need for multiple administration staff in multiple insurance companies (four presently) and the many regulatory bodies that will be required seems a very inefficient use of resources and waste of tax payers money."

One respondent noted that the change in administrative and delivery structures would inevitably entail a temporary loss of efficiency

"We need to avoid the loss of efficiency that always accompanies radical and rapid structural change."

Another respondent, within the health insurance industry, expressed the view that it is unclear from the White Paper what the Government's policy intention is regarding the contractual position and remuneration of hospital consultants under UHI, which they believe is a significant oversight in terms of the detail on how the UHI system is intended to operate in practice:

"It is not clear from the White Paper what the policy intent is in relation to the contractual position and remuneration of hospital consultants. This leaves a significant gap in the picture provided of the overall delivery and payment mechanisms for universal healthcare across public and private hospitals with the goal of providing single tier access."

"The White Paper however is entirely silent on how consultants will be reimbursed within a UHI model, whether consultants will be paid per procedure by insurers, whether consultants will be paid salaries by hospitals for services rendered or whether consultant cost will be amalgamated with general agreements between insurers and hospitals."

Bureaucracy and administrative burden is associated with themes such as:

- **complexity**, in particular, as the number and variety of organisations anticipated to be involved in the new UHI-based system is cited by respondents as a key factor in the complexity they perceive within the proposed reforms;
- **cost** – as noted, the costs associated with having a wide range of organisations involved, both from the perspective of duplication of administration costs, and from the potential for complex and costly processes required to ensure communication and effectiveness;
- **integration of care**, owing to the perceived potential for issues in ensuring information flows efficiently and effectively and that the various organisations work together to ensure that care can be delivered where needed.

3.3.13 Theme L: Complexity

Theme L: the proposed structures and funding systems appear very complex

As mentioned above, respondents perceive the proposed UHI-based system as set out in the White Paper to be very complex. This complexity is considered by participants to stem from the proposals to have a long list of agencies and other statutory bodies involved in the operation, delivery, and management of healthcare, as well as from the multi-payer UHI funding structure proposed.

"The proposed organisational structure for UHI is very complex."

Anticipated problems relating to the perception of complexity cited by respondents include issues in respect of:

- cost control;
- integration of care;
- bureaucracy;
- communication;
- regulation;
- access to care.

Some cited the Dutch model's complexity as evidence that such systems do not, in respondents' opinion, represent the optimum model:

The Dutch experience also shows how difficult it is to achieve desired access and control cost within a complex system.

"The White Paper outlines that there are roles for many other bodies within the public domain and there is a very large regulatory requirement (and therefore administrative requirement) set out in the White paper, around health insurance companies, providers etc."

Opting for the proposed multi-payer model will, in some respondents' opinion, increase complexity and its associated issues for integrated care, for example:

"All evidence supports having only one body responsible for funding health care for an individual, and any alternative requires complex and non enforceable rules about what is the responsibility of whom."

Some participants were of the view that Ireland represents too small a population to realise the potential benefits of a competitive multi-payer system:

"If regulation prevented consolidation of the health insurance market under UHI in Ireland that would probably mean that the competing insurers would all be operating well below the minimum efficient scale."

This theme is associated with others including:

- **bureaucracy/administrative burden** – one key issue for many respondents is that the complexity of the proposed system will increase bureaucracy;
- the perception among respondents is that the **complexity** of the system may involve increased operating and implementation costs;
- **integration of care**: some believe that the complex system proposed may hinder the ability of patients to move between types of care and care provided under different funding mechanisms;
- the lessons from the **Dutch model** were cited by some in relation to the complexity therein.

3.3.14 Theme M: Two-Tier System Continued

Theme M: UHI as envisaged in the White Paper may still comprise a system where supplementary insurance, out-of-pocket expenditure, and co-payments mean that those on higher incomes may be able to access more

Respondents noted that the stated aim of the White Paper's proposed reforms is to deliver a single-tier health service with equity of access. Many respondents noted the references to potential additional payments in the form of, for example:

- supplementary insurance;
- co-payments;
- out-of-pocket payments.

For some respondents, these references to additional payments appeared to contradict, in their opinion, the overall objective of the White Paper in terms of universal healthcare.

Participants made a number of references to their view that a system that enables those who can afford additional payments to access certain types of health services was, by definition, a two-tier system.

"UHI will not in itself eliminate the single tier system as some element of multi-tier access will continue to exist."

In particular, the reference to supplementary health insurance was discussed in relation to this:

"The presence of a market for supplementary health insurance will mean a continuation of a two-tier healthcare system, albeit for different benefits."

"Supplementary insurance should not cause the development of a system whereby people with enhanced insurance cover can gain enhanced access to diagnostics and treatment."

As one respondent noted, the proposals to include elements such as supplementary insurance would perpetuate the current inequities.

"As a result we will simply be reshuffling our two-tier system of healthcare to a system where those who can afford supplementary private health insurance will have access to a wider range of care while those without are limited to a standard basket of care with high out of pocket co-payments."

Out-of-pocket payments were also a source of concern to some respondents:

"Out-of-pocket payments are known to deter both necessary and unnecessary care and should not be applied to low income groups and those with long-term illness."

"The potential for additional out-of-pocket expenses will be of concern to people on low incomes who can currently estimate any additional expenditure they may incur in terms of prescriptions and GP costs."

Not all respondents were entirely opposed to co-payments, however, noting that they avoid the "moral hazard" issue of utilising health services more than necessary because such services are free at the point of access; some submissions also suggested that co-payments ensure appropriate value is placed on the service provided, whilst others questioned whether this was fully effective:

"Co-payments are an absolute requirement to control demand and make people understand that a service has an economic value."

"Co-payments are another regressive form of funding, although they can help to mitigate moral hazard."

"The moral hazard problem…can…be reduced by adopting a budget shifting approach and requiring the individual patients to pay a charge or make a co- payment…While in theory, co-payments should keep down the costs of treatments and services, the evidence base on co-payments systems raises doubts over whether they achieve any real benefits."

This theme relates to several other themes, as follows:

- the issue of **costs**, in particular the potential costs to the individual or household, in terms of payments over and above the UHI premium;
- the **debate as to whether UHI is the best model** to choose for the reform of the health system;

- the **different services funded by different mechanisms** and who will be required to pay what for which service;
- the perceived **lack of clarity and detail** on the proposed costs and potential breakdown of these across UHI, supplementary insurance, out-of-pocket payments, and co-payment.

3.3.15 Theme N: Defining which Health Services Are Funded by which Source

Theme N: some health services will be funded by UHI and some directly; there may also be others for which supplementary insurance will pay

Respondents noted the proposals in the White Paper to fund different elements of health service delivery in different ways, i.e.:

- some health care services (the "basket of services") by means of the multi-insurer UHI model;
- other health and social care services, such as long-term care and emergency response services, with direct State funding;
- potentially also these and/or additional services by means of supplementary insurance, out-of-pocket payments, and/or co-payments.

"UHI proposes a divergence in the funding of social care services. It is recognised that the White Paper outlines the intention of the state to fund acute and primary services within the "basket of services" but other services such as day care services and residential services will be funded by taxes."

"There is a risk under a multiple-funder, multiple-provider system of fragmentation of authority over mental health care, e.g. acute care covered by UHI while community-based and social care is funded by others."

This causes concern among some respondents in respect of those who by virtue of their health status (e.g. those with disabilities) may need to access a range of health and social care services, potentially funded in different ways.

"There is significant potential for tension between the Universal Health Insurance and non-Universal Health Insurance system for people with who need to move from one part of the system to another."

The White Paper confirms that Social Care services will be outside the Universal Health Insurance system and continue to be funded by the tax system…The interface between the wider health system, the elements to be funded by Universal Health Insurance, the health elements to be funded by general taxation, and the care system will be particularly critical to ensure that people with disabilities continue to have access to the quantum of service they need and in a seamless manner."

Respondents have concerns that a separation of funding will be a hurdle to the integration of care:

Amongst them is how to deliver a truly integrated system of care, especially for people with complex or chronic conditions, within a system in which primary and hospital care is to be funded through the proposed Universal Health Insurance system, but social care services, including long-term care, are not.

"As recognised in the UHI documents and in the review undertaken by the Health Research Board for the Department of Health, the integration of care between the different levels of care (primary, acute, long-term) is particularly difficult in a system where care is financed through differing mechanisms (activity-focused insurance system and a taxation system)."

Some submissions cited evidence that such divisions in funding mechanisms hinder the delivery of optimum care:

"Research (Ex, Gorter and Janssen, 2003) into the UHI model in the Netherlands (similar to the one being proposed with a division in how social care and medical care are funded) has shown that the divide between reimbursement for social care and medical care impedes a further development of the community care systems."

Similar concerns could be seen in submissions relating to particular patient groups among others, citing anticipated problems with the proposed structures in relation to the delivery of care to those with whom they work. Some submissions considered that the divisions proposed in relation to the services to be included in the basket of services and those proposed to be funded in other ways did not reflect patient need.

"The time period dividing UHI funded and taxation funded social care services is arbitrary."

One particular area of concern within submissions in this respect is the issue of rehabilitation services, and especially the proposal in the White Paper that the basket of services would cover rehabilitation of up to one year in duration. Some respondents suggested that the particular care needs of people with particular conditions and disabilities would not be addressed by time-based rehabilitation services.

"Rehabilitative care is covered under the standard UHI package up to one year. This would appear to be an arbitrary cut off point, not based on clinical need… Rehabilitation should be goal oriented, not time limited."

"How does the one year time frame work that is proposed in the UHI framework in this situation when the individual will require multiple interventions from many specialities often from the time of diagnosis and throughout their journey with MS."

This theme is associated with several others, including:

- a strong association with the issue of **integration of care**, as discussed above, respondents express concern that the division of services between different funding mechanisms will impede integration of care;
- the issue of the **two-tier system** is also related, as respondents queried whether access to the various services might in some cases be dependent on ability to pay supplementary insurance or co-payments;
- the **complexity** perceived to be inherent in a system with multiple funders evidently relates to the theme concerning the respondents' view of the UHI system as complex;

- the theme concerning **community and continuing care** is associated with this theme, as respondents questioned how social care in particular would be funded and accessed under the proposed reforms.

3.3.16 Theme O: New Tax by Another Name

Theme O: the introduction of compulsory UHI means that individuals and families will be paying additional amounts for what is currently paid out of taxation revenue

A view expressed by a number of respondents, among them many of the private individuals responding, was the perception that the proposed system of compulsory UHI payments represents an additional tax burden on individuals and households.

"The proposed Universal Health Insurance scheme can be seen in no other light than a new tax."

"Since UHI will be compulsory it is in many ways akin to a tax."

"In my view its another way to collect tax from us in middle Ireland…I pay PRSI/USC each week for what benefit to me? And now you want to tax us more."[5]

Some submissions question the introduction of UHI, given the current contribution in the form of universal social charge and pay-related social insurance:

"We on low income already pay universal social change (USC) and PRSI. Where is the money collected from USC/PRSI going?"

"For those who are working they are already paying USC PRSI which includes a health element and tax."

Some respondents articulated concerns that not only could UHI be considered a form of additional taxation, by its nature it may not be a progressive form of taxation:[6]

"UHI premiums may also be viewed as a regressive form of taxation as most people at work will be mandated to pay the same charge irrespective of income levels."

"The system of subsidizing those on low incomes is in general a much less equitable system than one based on progressive taxation as it does not allow for adequate contributions being made by those "very high earners" who although numerically small earn disproportionate percentages of the national income."

A number of respondents, in particular some of the academic participants, suggest in their submissions that the Department consider this issue carefully:

[5] A number of respondents mentioned the payment of PRSI and/or USC in the context of contributing to the funding of the health services. It should be noted that these are respondents' perceptions of the manner in which PRSI and USC operate: in fact, PRSI funds the National Social Fund, with only a very small percentage going to healthcare (in the form of optical and dental benefits), and USC goes to general taxation.

[6] Progressive taxation entails those on higher incomes paying a larger amount of tax.

"If people are to start paying into UHI they would expect at least some of this to be reflected in lower tax, private insurance costs or fees… Current public spending on public health service provision is similar to the total revenues raised in income tax. Thus on average people contribute to the public health system everything they pay in income tax. If they start to contribute through UHI premiums they might expect their tax burden to fall by approximately what they current pay in income tax."

"To aid consumer acceptance, and in the interests of equity, concurrent with the requirement for citizen funding of the basic UHI there should be a broadly commensurate and clear reduction in direct taxation, such as by reduction of the Universal Social Charge, increase in Income Tax thresholds, or reduction in taxation rates. In other words, introduction should be demonstrably cost neutral, and able to rebut any claims of being a 'stealth tax', or a reduction in health service cover in Ireland."

This theme relates to a number of other themes:

- this issue is closely related to that of **cost**, with concern expressed by respondents that the UHI payments required of individuals and households under the proposed reforms will be additional to rather than in place of current contributions to tax, USC, and PRSI in relation to health service funding;
- this is also related to the perceived **lack of clarity** and definition in respect of the future costs of the UHI system to individuals and households; in the absence of definitive information in relation to the level of UHI premiums and the thresholds for financial subsidies thereof, respondents are concerned at the potential additional burden.

3.3.17 Theme P: Potential Influence of Insurers on Healthcare Decisions

Theme P: concern that medical decisions may be driven by health insurers rather than based solely on the best interest of the patient

One aspect of the reforms proposed within the White Paper about which disquiet was expressed within the submissions was the perceived potential for healthcare decisions to be driven by insurers' interests rather than patient need.

"The big risk in health systems with multiple payers (whether these are all public or a mixture of public and private) is cost shifting. Put simply if there are multiple funders a good strategy for any funder is to shift cost to another funder."

"Medical need rather than economics must be central to decision-making. This may be hard to achieve in a system that is funded by for-profit health insurance companies."

"There is the potential that the commissioning process will lead to managed care with decisions made by insurance companies for cost reasons rather than clinical needs."

There is concern in some submissions that doctors may be placed in a difficult position in terms of treatment options, whereby the restraints of the competitive, for-profit system are at odds with the best interests of the patient in terms of optimum care:

"Commercialism substitutes the doctor patient relationship with a provider-customer relationship and the goal of curing the patient is substituted with the goal of profit. Physicians are faced with a moral and ethical conflict between the needs of the patient and economic imperatives…A commercial competitive environment will inhibit doctors from reaching value judgements which are not in the interest of the patient or the State."

Respondents express in the submissions a desire to see such potential behaviour limited within the regulatory structure of the UHI system, such as this comment from an organisation representing people with neurological conditions:

"It is important that regulation and standardisation of services and the availability of guidelines for the management of neurological conditions is developed in advance of any purchasing power by insurers so that insurers are making decisions based on appropriate standard of care rather than associated with cost, e.g. limiting hospital cover and discharging to community based services because they are cheaper."

Health insurers do not share the concerns of other respondents to the same extent, expressing a desire to be involved in the purchasing of care on behalf of their customers:

"We believe the current role of insurers as funders of the system should be expanded to include the provision of access to services for their customers…Thus insurers should be the purchasers of care on behalf of their customers."

This theme is associated with others such as:

- the **debate on whether the multi-payer UHI model is most appropriate**, as this issue is one of the concerns respondents express in the submissions in relation to a competing-insurer model;
- the issues around **defining which services are funded by which mechanism** is related here also, especially in relation to the possibility that patients may be "shifted" from one funding stream to another on the basis of cost avoidance rather than medical need;
- **integration of care**: respondents are concerned that decisions may be made by insurers on the basis of cost/profit rather than the optimum care for patients, which may hinder the implementation and operation of integrated care pathways.

3.3.18 Theme Q: Community and Continuing Care

Theme Q: the role of community and continuing care in the health system as envisaged by the White Paper

According to many of the submissions, participants perceive a lack of definition in relation to the role and funding of community and continuing care within the proposed UHI system. Although respondents note that the White Paper states that community care will be funded directly rather than through UHI premiums, as some point out, the detail is lacking in how this will operate.

"It would be important to clarify how other essential, community-based services…would be funded and provided."

"Details on how funding will be allocated to the different services the Fund will finance directly are not outlined."

The current entitlements to community-based care for those on medical cards, the lack of clarity as to the future entitlements for these individuals, and future access to such care for others, were mentioned in a number of submissions.

> *"There is further lack of clarity in respect of whether public community and primary care services that are currently only available without charge to those with medical cards will be free at the point of delivery for the whole population."*

Some indicated that they believed that more resources need to be allocated to the community care sector in order to support the introduction of the reforms:

> *"The introduction of UHI can only be considered with much greater investment in community care services."*

One submission noted the difficulty in defining the line between various types of community-based care (such as clinical and social care) in terms of the services currently delivered by public health nurses (PHNs):

> *"Further consideration should be given to the inclusion of other health and wellbeing services which are currently integrated into the role of the PHN and which may be very difficult to disentangle."*

This theme relates to a number of others as follows:

- the **lack of clarity** about the funding and integration of the community and continuing care sector within the proposed UHI system was of concern to some respondents;
- concern regarding the **capacity of the current system** to support the reforms: respondents suggested that additional investment is required in current community care services to ensure the capacity to deliver under UHI;
- the **definition of which types of services will be funded by which mechanism** is particularly relevant to this issue for many respondents, because of the proposal to fund community care directly rather than via UHI;
- the issue regarding the **future entitlements of those currently holding medical cards**, given the expanded set of entitlements to types of community and social care available to medical-card holders.

3.3.19 Theme R: UHI May Not Support Integrated Care Pathways

Theme R: the proposed funding structures may hinder smooth transitions between various forms of care

The issue of the integration of care across a number of settings and a range of health and social care services was the focus of many submissions to the consultation process. Many respondents stated that they had concerns regarding the proposed reforms and their capacity to develop and implement integrated care for patients. One submission expressed concerns regarding the proposed hospital structures, for example:

> *"…some concerns about the proposed governance model for the health service including the establishment of independent Hospital trusts. We would be concerned about the possible impact this would have on the integrations between hospital and community care services."*

Another considered the proposals for emergency department funding as counter to the aim of integrated care:

> *"In our view, on the current proposals, there is a serious weakness in the proposed integration between the health services outside of UHI and those in the standard package, and that is the published plan for funding emergency departments."*

Several others raised their concerns regarding anticipated problems ensuring integration of care with multiple funders and providers within the UHI system.

> *"It is difficult to see how integration of service delivery can be provided by a disparate group of service purchasers without some over-arching authority that has the power to require integration."*

The exclusion of social care from the basket of services to be covered by UHI concerns some in relation to the integration of care:

> *"This exclusion may present serious issues for integration and joined-up services across primary, community and acute care."*

Some patient advocacy groups highlighted their concerns in relation to the integration of care for those with particular conditions and associated multiple health and social care needs, such as those with disabilities, those with mental health difficulties, and those with chronic conditions:

> *"The system will need to appropriately and effectively meet the needs of people who experience more than one condition. The UHI will need to be designed to ensure that individuals who have both physical and mental health care needs or who have more than one physical condition can get adequate, integrated community and acute care from the relevant providers. The way in which the system provides for these more complex cases will be the true test of its effectiveness."*

> *"The current majority provider HSE also brings the benefit of defining a single point of authority for managing mental health service delivery (the National Director for Mental Health). There is a risk under a multiple-funder, multiple-provider system of fragmentation of authority over mental health care, e.g. acute care covered by UHI while community-based and social care is funded by others."*

> *"Coordination and Integration of Care, especially for the increasing numbers of people with chronic conditions, often with double or triple co-morbidity, is a quality and an economic issue."*

This theme is associated with a number of others, including:

- **defining which services will be funded by which payers**, as this is a core concern expressed by respondents in respect of potentially impeding the implementation of integrated care pathways;
- respondents suggest there is a **lack of clarity** on the way in which integrated care will be supported within the UHI system;
- the **complexity** of the multi-payer system with a range of providers, insurers, and funding mechanisms is cited by some respondents as a concern in relation to integration of care;

- the **role of community and continuing care**: given the need for integrated care to include aspects of community and continuing health and social care services, the concerns expressed by respondents in relation to community care services relate to the issue of integration of care.

3.3.20 Theme S: Role of Not-for-Profit Organisations

Theme S: some health and social care in Ireland is delivered by the not-for-profit sector; the future integration of this care and the funding thereof is not clear in the White Paper

A number of submissions noted the role currently played in the delivery of some health and social care services by organisations in the not-for-profit sector and respondents queried the lack of detail in the White Paper on this aspect of health service delivery. For example, in relation to palliative care services, one respondent notes in their submission the significant involvement in the funding and delivery of such services by voluntary bodies, and recommends that:

"Clear mechanisms should be developed for the inclusion of the voluntary sector in the planning process, given that it leads and delivers most of the country's inpatient specialist palliative care services."

Another submission noted the cost implications of the current involvement of the non-statutory sector:

"A significant proportion of community based care is provided through the non-statutory sector …[t]he non-statutory services often supplement the statutory services, lowering the direct cost of care for such services."

The submissions suggest that the absence of detail in respect of the future role envisaged for not-for-profit providers under UHI is an issue for some respondents.

"The Framework and supporting documents for UHI outline in detail how the current services provided within the health system will operate under UHI. There is little or no information on how the proposed model will apply to services currently commissioned from not for profit providers."

"We are anxious that this vital role of disability organisations gets recognised, and doesn't get lost if their funding continues to be state driven and not funded through Universal Health Insurance…We would encourage the Department to consider how the sector can play a role in supporting mainstream services to effectively provide health and social care to people with disabilities."

This theme interrelates with a number of other themes:

- the issue expressed by respondents in respect of **defining which health and social care services are funded by which source**, in that it's unclear to many respondents how services currently delivered by the not-for-profit sector, funded or part-funded by the State, will feature within a UHI-based system.
- the issues around the **integration of health and social care services under UHI** is strongly related to this theme, in terms of the perceived lack of detail about the services currently delivered and/or supported by the voluntary sector;

- the lack of detail evidently overlaps with respondents concerns about the **lack of clarity** and definition contained within the White Paper about the full implications of the implementation of UHI.

3.4 Consultation Process

3.4.1 Preamble

The Department of Health had, as discussed in Section 2.2, developed a consultation document with a series of questions as a suggested framework for the submissions to the consultation process. As already noted, fewer than half of the submissions used the Department's consultation document structure to respond to the consultation process, and of those, a considerable number did not answer all or in many cases even most of the questions therein.

3.4.2 Issues with Consultation Document

Respondents made comments in relation to the structure and content of the consultation document, noting that for many it did not reflect the issues they wished to address within their submissions, and/or that it was concerned with technical elements of the proposed reforms.

"…welcomes the opportunity to contribute its views on UHI but is disappointed with the format of the consultation. The template used to elicit responses is prescriptive and restrictive."

"Many of the Health Care Providers who were asked to respond to this questionnaire had no views as: a. Could not understand much of its content; b. No time to read such a lengthy document."

Consequently, we have not structured the thematic analysis to address the individual consultation document questions, given the lack of engagement by many respondents with the document structure, and the evident concern expressed within the submissions as a whole with a range of issues not directly addressed by the consultation document content. Nonetheless, we recognise that some of the questions posed within the document did garner some responses, and we set out a very brief outline below of the responses in relation to these particular issues, where such issues have not formed part of the key themes already set out above.

3.4.3 Themes Arising from Consultation Document Questions

Values Framework

The consultation document requested respondents to set out their views on the proposed development of a values framework within the White Paper. In general, those who addressed this issue support the principle of a values framework to underpin the health reform agenda, in part or in full, but considered that further development and debate on this was required.

"The values framework is very important and underpins the whole UHI strategy. We would argue that this in fact, is a broader societal issue that requires a deeper conversation with the people about what kind of health system we want and how do we want to pay for it."

"We welcome the proposed values framework. However we are of the view that a social value proposition also need to be incorporated through shared values."

"Patients must be at the heart of the values framework to ensure that the model is truly needs-based."

Some respondents were of the view that the development of a values framework was a complex and challenging process, requiring careful consideration and potentially external expertise.

"Publicly decided values are always a challenge. Experience elsewhere has shown that what seems good in principle has problems in practice."

"The complexity of the work…is significant, time consuming and costly. However the value of eliciting society's values in this way allows the information extracted to be applied within a systematic framework. The proposal in the White Paper suggests that the Joint Oireachtas Committee on Health and Children together with the Commission will perform this work; due to the complexity of translating these responses into a framework which can be applied in practice. [We] advise that this be carried out by those with expertise in preference elicitation and not by the Commission and Joint Oireachtas Committee on Health and Children. Investment in a state sponsored research study to independently elicit the health preferences of society in Ireland are essential to enable clear equitable decision making for health."

Regulatory Issues

Another area to which a number of participants provided observations was in relation to regulatory matters. Overall, respondents were in favour of regulation across all aspects of the proposed UHI system.

"Health Insurers should be required to follow all regulations, including financial regulations, internal governance, management requirements etc as laid down by the insurance industry and the Insurance ombudsman…Healthcare providers should be required to comply with HIQA's standards only. They should not be subjected to dual regulation i.e. HIQA's standards plus separate standards imposed by the Health Insurer."

Some submissions expressed concern in relation to potential difficulties and costs associated with regulating what is perceived by some respondents to be a complex system.

"In general, there will be a need for significant additional resources to ensure adequate regulation of healthcare providers and insurers, and it is unclear where the money to pay for this will come from."

"Regulation of insurance companies is difficult especially in health insurance."

"There is a need to ensure guidelines and regulations take account of the differences between the provision of services in community settings and those in acute hospital services."

Some respondents, in particular private health insurers, were concerned about the potential for over-regulation:

"There would appear to be a large number of regulatory bodies proposed as part of the UHI model. While we understand the necessity to safeguard patient access and care we would suggest that serious consideration be given to reducing the number of proposed regulatory bodies as the detail of UHI is finalised."

"Regulation should not create the wrong incentives within the system nor inhibit competition. The proposed system as outlined in the White Paper is overregulated in some areas."

As mentioned within Theme B, health insurance providers in particular expressed the opinion that the proposed regulatory measures may hinder the development of the desired competitive insurance market under UHI.

"The proposals on caps on insurer profits, expenses and claims. Such caps may be detrimental to the market as a whole. For example, the market may not remain attractive to a sufficient number of insurers and innovation may be stifled."

"With caps placed on premiums, ability to contract, profits, and overheads there is too much central control of areas that insurers would normally use to add value and deliver efficiencies."

Some respondents indicate the difficulty in operating such a set of controls:

"Implementing controls on insurers' UHI expenses and profits will be very difficult where insurers operate multiple lines of business."

Several also question the legal capacity of the Government to impose specific controls on overheads or profits within private companies.

"[We] would question the constitutionality of placing caps on the commercial freedoms of insurers within the market. In particular, caps on administration costs or a cap on profits would seem to unnecessarily restrict the rights of business to operate in Ireland."

"Even if they are both legal and feasible, they could act as a deterrent to new insurers entering the Irish market."

4 Concluding Comments

A considerable body of material was reviewed as part of this assignment for the Department of Health, covering 137 submissions from a wide variety of individuals and organisations.

The White Paper on UHI set out a radical change in the way that health care in Ireland could be funded in the future. Both before and after its launch, this proposed policy was the subject of much public discussion. Therefore, it may have been expected that, given the level of debate and the scale of the change proposed in a sector that is at the heart of Irish society, there might have been a higher level of response to the Department of Health's call for submissions. However, it should be acknowledged that many of those who did respond represent a significant breadth of opinion and are key stakeholders in the health sector and wider society.

The diversity of the submissions has heavily influenced the thematic analysis which we have been able to perform and to present in this report.

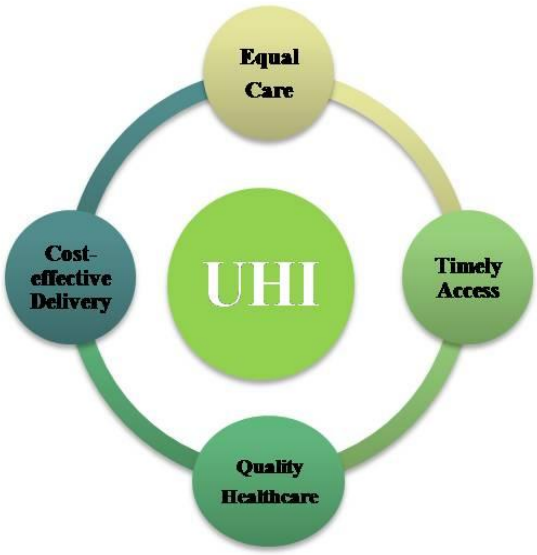
Overall, while there was a substantial level of support for the reform of health services to bring about a single-tier health system with equity of access, the strong sense emerging from our analysis of the 137 submissions is that those who participated in the consultation process are generally unconvinced by the UHI proposals. Those who have submitted their views because they want better access to care for themselves or for their relatives, or who are advocating on behalf of people suffering from a specified condition, are typically apprehensive that UHI will result in a reduction in access and a deterioration in service quality. In similar fashion, very many of those respondents who have professional experience in, or interaction with, the healthcare sector, such as clinicians, academics, or business executives, point to a lack of detail surrounding the efficacy and financial sustainability of UHI in practice, and wish to see more evidence to support the proposals.

A rich body of material has been provided by respondents in their consultation submissions following the publication of the White Paper, and many have expressed their hopes that their views and opinions will be taken into account by the Department and the Minister as the UHI policy is further developed.

It is evident that the weight of opinion within the submissions is that significantly more detail and information is required in respect of the proposed reforms and that the respondents call for more debate on all aspects of the proposals.

Appendix 1
Consultation Paper Issued by the Department of Health

Public Consultation on the White Paper on Universal Health Insurance



The information collected from the submissions made through this consultation process will be used for the purposes of informing the policy development of Universal Health Insurance. With reference to the Data Protection Act, 1988 and the Data Protection Amendment Act, 2003, the Department of Health will be producing a report on the consultation process, and information provided may be included in this report. Please note that all information and comments submitted to the Department of Health for the purpose of this consultation process are subject to release under the Freedom of Information Acts 1997 and 2003.

1 Personal Information

1.1 Are you completing this document:*

- ○ In a personal capacity
- ○ As an authorised representative of an organisation/body, expressing the views of that organisation/body.

1.2 Name:*	

1.3 Organisation: (mandatory if you select the second option at 1.1)	
1.4 Please classify your organisation type: (mandatory if you select the second option at 1.1)	
○ Health Insurer or Other Insurer ○ Public Health Service Organisation / Provider ○ Private Health Service Organisation / Provider ○ Union ○ Educational Sector	○ Public Interest Group ○ Patient Interest Group ○ Regulatory Body ○ Representative Body ○ Other

2 Overview

The White Paper on UHI sets out the policy vision for the most radical ever reform of our health system. The major overhaul of the system will see a move away from a two-tier unequal health system to a single-tier system where access is based on need and not on income.

The key features of the UHI policy are:

- Everyone will have mandatory health insurance and their choice of insurer.
- Everyone will be entitled to the same package of care, which will include primary and acute hospital services, including acute mental health services. There will be no distinction between 'public' or 'private' patient; access to treatment will be on the basis of medical need, rather than ability to pay.
- Health services which will continue to be government funded and available outside of the UHI package include social and continuing care services, non-acute mental health services and certain social inclusion services.
- Citizens will be given a number of protections under UHI: they will be able to switch insurer annually, they will have the right to renew their policy and they will be charged the same premium for the same policy irrespective of age or risk profile.
- Citizens will also be afforded financial protection. The Government is committed to paying or subsiding UHI policy premiums for those who need support through the new National Insurance Fund.

The White Paper seeks to further develop the above features of the model by setting out a blueprint of how our future health services will be funded, organised and delivered. On that basis this consultation document sets out a number of key questions under the following four headings:

- Proposed Organisation and Delivery of the UHI Model
- Policy and Operational Aspects of the Subsidy System
- Regulation of Healthcare Providers and Purchasers
- Funding of the UHI model and the Overall Health System

You are invited to give your views, in writing, on some or all of the issues raised. Please provide your response to the questions in each relevant box. If you have no views to offer on a particular area, simply leave the box blank. There will be an opportunity at the end of this document for other observations/comments you may have on any aspect of the White Paper or to forward an email attachment.

Thank you for giving us your views.

3 Proposed Organisation & Delivery of the UHI Model

3.1 When the UHI system is in place, health insurers will be responsible for purchasing care on behalf of the population. Do you have any views on safeguards that should be built into this system, e.g. timely access to care, geographic limits etc.?

3.2 Do you have any views on the role of the National Insurance Fund in (a) directly financing certain services and (b) being responsible for the financial support payments system?

3.3 How, in your view, can integration between health services outside of UHI and those in the standard UHI package best be achieved?

3.4 What should be the priorities for phasing the delivery of the UHI model i.e. with full implementation by 2019?

3.5 Do you have any views on the role of supplementary insurance under the new system?

3.6 The White Paper sets out a proposed values framework to guide the work of the Commission in assessing what services should be included under UHI and the overall health system. Do you have any views on this values framework?

4 Policy & Operational Aspects of the Subsidy System

4.1 Do you have any views on how the subsidy system for UHI should operate i.e. how can we ensure that it protects those on low incomes?

4.2 The White Paper notes that the financial subsidy system will be provided on a means tested basis. Do you have any views on whether this assessment should be solely based on income or if other factors such as assets should also be included?

4.3 Some members of the population currently have entitlements under various schemes e.g. medical cards, GP visit cards, Long term illness scheme etc. Do you have any views on how these benefits may best be delivered when UHI is introduced?

5 Regulation of Healthcare Providers & Purchasers

5.1 Do you have any views on the proposed system of regulation of healthcare providers and health insurers? Are there any areas you would like to see strengthened?

5.2 Do you have any views on how the management of contractual disputes regarding health insurance might be best achieved?

5.3 Do you have any views on what economic regulation mechanisms should be applied to ensure good governance and financial management of health services?

6 Financing of UHI and the Overall Health System

6.1 Do you have any views on the proposed new financing model for UHI i.e. a blend of premium income, direct taxation and out of pocket payments?

6.2 Do you have any views on the use of co-payments for services?

6.3 Do you have any views on the cost control measures that have been set out in the White Paper? Are there other cost control measures that could be implemented?

6.4 In your view, how best can the regulatory systems set out in the White Paper provide the state with sufficient means to safeguard the financial sustainability of the health system and secure ongoing affordability of UHI policy premiums?

6.5 Do you have any views on how the regulatory and administration costs of the system might be minimised?

7 Additional Comments / Observations

Should you wish to provide comments on any other aspects of the White Paper please do so in the box below or attach a document in the email response.

Appendix 2
List of Respondents

Overview

As stated in the main body of the report, 137 responses were received, as follows:

Categories	Number	%
Private Individuals	39	28.5%
Advocacy / Patient / Public Interest Groups	38	27.7%
Union / Representative Body	20	14.6%
Educational / Research Sector / Academia	16	11.7%
Health Service Organisations	10	7.3%
Health Insurers	4	2.9%
Pharmaceutical Companies	3	2.2%
Government Departments	3	2.2%
Regulatory Bodies	3	2.2%
Political Parties	1	0.7%
Total	137	100.0%

List of Respondents

Private Individuals	
39 submissions from private individuals	
Advocacy/Patient/Public Interest Groups	
Acquired Brain Injury Ireland	Irish Human Rights Commission
Age Action Ireland	Irish Lung Health Alliance
Amnesty International Ireland	Irish Patients Association
Association of Optometrists Ireland	Irish Platform for Patients' Organisations, Science and Industry
Asthma Society of Ireland	Irish Senior Citizens Parliament
Axis Consulting	Irish Society for Colitis and Crohns Disease
Care Alliance Ireland	Irish Thoracic Society
Citizens Information Board	Mental Health Reform
COPD Support Ireland	Multiple Sclerosis Ireland
Cuidiú - Irish Childbirth Trust	National Disability Authority
Cystic Fibrosis Ireland	Neurological Alliance of Ireland
Disability Federation of Ireland	Pavee Point
Disability Federation of Ireland – C&V Pillar	Publicpolicy.ie
Down Syndrome Ireland	Rehab Group
Epilepsy Ireland	Social Justice Ireland
Irish Cancer Society	St Vincent de Paul
Irish Heart Foundation	TASC – Think Tank for Action on Social Change
Irish Heart Foundation Council on Stroke	The Alzheimer's Society
Irish Hospice Foundation	The Carers Association

Union/Representative Bodies	
Federation of Irish Complementary Therapy	Irish Pharmaceutical Healthcare Association
FODO Ireland	IBEC
ICGP	Independent Hospitals Association of Ireland
IHCA	Insurance Ireland
IMPACT	Irish Association of Speech and Language Therapists
Institute of Community Health Nursing	Irish Association of Speech and Language Therapists in Private Practice
Irish Association of Older people	Irish Pharmacy Union
Irish Medical and Surgical Trade Association	Nursing Homes Ireland
Irish Medical Organisation	Retired Workers Committee of ICTU
Irish Nurses and Midwives Organisation	Society of Actuaries in Ireland
Educational / Research Sector / Academia	
Adelaide Hospital Society	Irish Longitudinal Study on Ageing (TILDA)
College of Psychiatrists of Ireland	Dr Brendan McElroy/Dr Aileen Murphy, UCC
Cork Specialist Training Programme for General Practitioners, UCC	Dr Mark Murphy, RCSI
Cork Specialist Training Programme for General Practitioners, UCC	Prof Charles Normand, Trinity College Dublin
ESRI	Prof Michael Rigby, School of Public Policy & Professional Practice, Keele University
Health Management Institute	Royal College of Physicians of Ireland
Institute of Obstetricians & Gynaecologists	Dr Brian Turner, UCC
Irish Faculty of Primary Dental Care	Cathal Walsh, Trinity College Dublin
Health Service Organisations	
Assistant National Oral Health Lead, HSE National Oral Health Office	HSE National Office for Health and Wellbeing
Beechlawn Medical Centre	National Centre for Pharmacoeconomics
Boots Ireland	Saint John of God Hospital
Children's Hospital Group	St. Patrick's Mental Health Services
Clinical Assessment and Therapy Teamed Services (CATTS)	West/North West Hospitals Group
Health Insurers	
Aviva	VHI
Laya Healthcare	GloHealth
Pharmaceutical Companies	
MSD Pharmaceuticals	Sanofi Ireland
Novartis Ireland	
Government Departments	
Department of Social Protection	Revenue Commissioners
Department of Justice & Equality	
Regulatory Bodies	
Irish Medicines Board	Medical Council of Ireland
Health Information and Quality Authority	
Political Party	
Sinn Féin	