Universal Health Insurance
What is it and would it be effective in Ireland?

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Introduction

The Irish health care system is failing to meet the needs and expectations of Irish people in so many different areas where care ought to be provided.[1] Dominating a range of failures in the system is the fact that care is provided in an inequitable manner. This is despite the stated commitment of the 2001 Health Strategy, *Quality and Fairness*, and of its 1994 predecessor, *Shaping a Healthier Future*, that 'equity' would be one of the core values underpinning Irish health care.[2]

The most striking examples of lack of equity in the system occur in hospital care: in effect, people on higher incomes are treated in preference to poorer people in a system where capacity is not adequate to care for everyone at the point of need. In addition, the quality of service given to those who can afford to use private care is superior to that given to those who cannot afford it – in terms of speed of access, consultant care and accommodation.

Issues of equity arise also in relation to primary care. While those on the lowest incomes qualify for a medical card, and those a little better-off may be eligible for the doctor-only medical card, many individuals and families with incomes that are limited but just above the cut-off point for eligibility find themselves facing what are now significant levels of GP fees and prescription charges. It is families with children, and individuals and families experiencing chronic or recurring illness, who are most seriously affected by the lack of access to GP care free at the point of use.

Furthermore, there is an unequal distribution of GP services, with many poorer communities – the very communities most likely to have poorer health – lacking or having only limited availability of GP services. We have, in short, a 'two-tier' health system which does not treat every citizen fairly.

The question arises whether there is a better way to finance our health care so that every person will be treated fairly and will receive the care he or she needs. In particular, would universal or social health insurance be fairer and more effective than our present financing arrangements?

How is Health Care Funded at Present?

Currently in Ireland, we pay for the health system in three ways. The first is through taxation, including a health levy. (In the Supplementary Budget of April 2009 it was announced that this levy would rise from the existing 2 per cent of income, or 2.5 per cent in the case of higher incomes, to 4 per cent, with a higher rate of 5 per cent.[3]) The second is through out-of-pocket payments – for example, fees paid to GPs by those who do not have a medical card; fees paid to consultants in private practice by patients not covered by health insurance; fees to physiotherapists, dentists and opticians; charges for prescribed medicines. And the third is through supplementary private health insurance.[4]

The proportion of the population covered by this supplemental private insurance has increased significantly over the past twenty years – coverage rose from just over 30 per cent in 1989 to 40 per cent in 1999 and it now stands at around 50 per cent.[5] The increase of the past two decades reflects not just the growth in disposable income that occurred over the period but an increasing perception that without such coverage people would experience long delays in accessing hospital services and would receive inferior care.

It is the unique mix of public and private financing and provision which creates the 'two-tier' system of health care in Ireland. In fact, however, taxation accounts for about 75 per cent of total health care expenditure. Out-of-pocket payments account for 15 per cent and just 10 per cent is contributed by supplemental private health insurance.

Thus all Irish citizens publicly fund a system which then allows a relatively small percentage of private insurance funding to grossly distort the delivery of care in favour of those who can afford such insurance: truly a case of the 'tail wags the dog'. The current system 'rations' the care

provided, leading to the situation where we have long waiting lists for public hospital services, patients lying on trolleys in Accident and Emergency Departments while awaiting admission to a hospital ward, and instances of gross lack of care for those who need it.

The Irish health care system is very poor at relating performance and outcomes to the financial allocations provided: under the existing system, public facilities receive a fixed financial allocation in advance and have to 'ration' care to stay within their budget. The result is that they can find it more cost effective *not* to treat patients; in other words, there is no financial drawback to keeping people on a waiting list. Such a system is not efficient or effective.

What is Universal Health Insurance?

Universal health insurance is a means of paying for health care which has been adopted by many Western and Central European countries. It has its origins in a system of limited public health insurance introduced in Germany in the late nineteenth century. (The terms 'universal health insurance' and 'social health insurance' are often used interchangeably; I am using the former because it is the term which has tended to be used in the emerging debate in Ireland on this issue.)

Under a universal health insurance system, payment is made through mandatory (compulsory) or universal insurance premia (fees). It is essential to understand the difference between *social* (or universal) health insurance and *private* health insurance. Social health insurance is based upon the concept of social solidarity: it involves *all* citizens being covered and having equal access to care and treatment – to a common 'basket' or set of health services – for equal need, *and* all contributing to cover (insure) the risks of all people in respect of their health care needs. Private health insurance, in contrast, is an individual payment made to cover the risk of an individual and his or her dependants needing health care; by definition, it excludes those who have not been able to purchase it.

Features of UHI

There are many versions of universal health insurance (hereinafter referred to as UHI) in operation: the level of contributions and the range of services under UHI schemes vary from country to country. What is outlined here is a 'model' UHI system, the underlying principles of which are the provision of health care on the basis of need and the funding of care on the basis of ability to pay.

The following are key features of this model or 'ideal type' UHI system:

- All citizens are insured through the payment of premia to a social health fund (or funds); such contributions are based on income, not on the cost of services individuals are likely to use, and so factors such as age or pre-existing illness or disability do not influence the level of payment.
- Contributors pay such premia instead of the portion of taxation previously required to fund health services, and the revenue generated is kept *separate* from the Exchequer or State funds raised through taxation.
- The State pays or supplements the premia of those on lower incomes (for example, the medical card population in the Republic) and so every citizen is an insured patient with equal access to the health system.
- The health insurance fund (or funds) is used to finance care for insured persons.
- Care covered by the health insurance fund(s) may be delivered by public, private not-for-profit, or private for-profit health care providers.
- Access to treatment and care is determined by clinical need rather than ability to pay.
- Health care is free at the point of need.
- 'The money follows the patient' – in other words, the amount of revenue generated by hospitals and primary care centres is determined by the number of patients provided with treatment and care. Health care providers, whether public, private or not-for-profit, therefore have a strong incentive to care for as many people as possible as effectively as possible. This is in contrast to a system where allocations are 'fixed' for a set period and are then rationed.

The Advantages of UHI

There are five main advantages to UHI:

- It enables the provision of a one-tier system of hospital care, with access and treatment based on medical need, not income;
- It provides a way to deliver GP services free of charge at the point of usage for the entire population;
- It puts the patient 'first and centre';
- It is more transparent – citizens see what they are getting for their premia;
- It combines the promotion of social solidarity with more accountable and efficient public service provision.

It would be a very significant step forward for Ireland to develop a health system where each citizen is treated fairly with no financial discrimination. It would greatly help the reform of our public services if providers in the public sector were given a strong incentive to make the delivery of quality health services to citizens their top priority – a failure to do so would mean they would face losing their share of service provision, and of the accompanying revenue, as citizens sought to be cared for by providers in the private not-for-profit or for-profit sectors.

In UHI, the inevitable 'ups and downs' of the State's annual revenue collection and expenditure allocation processes are not relevant – the health fund(s) would be *separate* and citizens could see continuity in health funding and a direct link between the premia they were paying and the level of services provided. This transparency has the potential to generate greater public commitment to providing an adequate level of financing for health services and greater interest in ensuring efficiency in the use of resources.

UHI would help reform public services by combining social solidarity with another key democratic concept – 'subsidiarity'. Our current health system is excessively centralised. A UHI system by its nature facilitates the realisation of subsidiarity: more responsibility and capability are given directly to the actual providers of health care – hospitals and primary care centres, for example.

A Mechanism not a Policy

The authors of two detailed studies commissioned by the Adelaide Hospital Society to examine the feasibility of UHI in an Irish context strongly emphasise that UHI is a mechanism, not a policy: '[UHI] is a mechanism to achieve a policy and not a policy in itself'.[6] They note further: '... the design of a [UHI] scheme is, or should be, dependent on the objectives to be achieved in the health system, such as value for money or fairness.'[7]

- Are you VHI? Aviva? Quinn Health Care?
- No, I'm just sick *© F. McGrath*

In the Irish context, much of the discussion about UHI has centred on its potential to bring about greater equity within health care, which is understandable given the lack of fairness that so clearly characterises the current system. A study by Samantha Smith, *Equity in Health Care: A View from the Irish Health Care System* (published in April 2009), highlights the challenge of defining what is equity in health care, given the diversity of political philosophies propounded in Western societies.[8] The study points out that the definitions of equity in Ireland's current Health Strategy embody a number of different and sometimes conflicting principles. In general, however, these definitions lean towards egalitarianism. Yet, the reality is that in many respects it is libertarian rather than egalitarian principles that apply in practice in the funding and delivery structures of our health service.[9]

The consequence of the lack of clarity and consistency regarding the definition of equity in Irish health care is the presence of contradictory, ineffective and inequitable features throughout the system. The development of an explicit and coherent statement of equity would obviously be an essential 'first step' in devising a UHI scheme that aimed to be equitable as well as efficient in its financing and delivery arrangements.

Potential Problems

UHI is clearly not some kind of easy or instant solution to the problems of a country's health service. The appropriate design and cost-efficient management of a UHI system is crucial. If, for example, the contribution base for the scheme is too narrow, so that revenue generated is insufficient, it may result in government having to provide subsidies from general taxation and/or in the range of services made available being limited and co-payments for services being imposed. Confidence in and support for the system then suffers, resulting in the emergence of a separate set of services affordable only to those on higher incomes, and so a two-tier system is once more in place.

The introduction of UHI can be expected to lead to an increase in demand for health care. While this may include some inappropriate use of services, it is also the case that it will mean a health system now responding to real needs that previously went unmet because individuals could not afford to access care. There is, for example, evidence that in Ireland some people delay or do not seek primary care because of cost factors.[10] The outcome may be delayed diagnosis and in some instances serious consequences for patients and additional long-term demands on the health service.

It is vital that the capacity problems in our health system are rectified, whether or not we introduce UHI

In the case of Ireland, the question of increased demand following on the introduction of a system of UHI brings to the fore the need to address the long-standing capacity problems of our health system.

The capacity issue relates, firstly, to a shortage of GPs – we need more primary care doctors and we need them especially if we are to have primary care free to all at the point of need.[11] Capacity problems arise also in relation to hospital services – comparisons with other OECD countries show that Ireland needs more acute hospital beds and a greater number of hospital doctors.[12] We also require more long-term care facilities, rehabilitative services and community health facilities.

It is vital that the capacity problems in our health system are rectified, *whether or not we introduce UHI*. Regardless of the funding mechanism(s) adopted, there is a need to invest in our future health care system in order to meet the needs of our population. One of the studies carried out for the Adelaide Hospital Society showed that the costs associated specifically with the additional capacity requirements arising from UHI would account for around a quarter of the overall amount that should be invested to meet current and future capacity needs up to 2020.[13]

In a Time of Crisis is UHI Possible in Ireland?

Professor Tom Keane, who brought his Canadian experience to Ireland as Interim Director of the HSE National Cancer Control Programme, has stated: 'All the change in Canada was because of recessions' (*The Irish Times*, 14 February 2009). Now, more than ever, we need a fairer, more efficient and effective health service. Now is the time to reform our health financing arrangements whereby we ensure we get value for money and provide proper health care.

The two studies commissioned by the Adelaide Hospital Society to examine the requirements and costings of UHI in the context of Ireland's health care needs showed that, properly designed and planned, a UHI system could provide:

- Free GP care for all;
- Equal hospital treatment based upon clinical need for every citizen;
- More effective and efficient health care providers.

How Much Will UHI Cost?

The percentage of income or wealth which needs to be paid by or for each citizen in a UHI system obviously depends upon the size of the common 'basket' of services which are fully covered by the insurance. The analysis commissioned by the Adelaide Hospital Society estimated that a fully comprehensive health service for all would involve health spending as a proportion of GDP rising from 7.5 to 8.9 per cent or an increase of €2.1 billion in running costs at 2006 prices. This

would still be comparatively low in European Union terms.

Significant steps towards the ultimate objective of a comprehensive UHI system could be taken for comparatively little additional spending. For example, we could provide:

- Full medical cards to all children and young people up to the age of nineteen at an additional cost of just €160 million per annum (2006 prices);

- Full medical cards for *all* the population would cost a net €217 million extra on top of the €2.1 billion spent on primary care by the State and the €692 million which citizens now spend in the form of out-of-pocket payments.

Obviously, the economic downturn affects the costings and feasibility of introducing a UHI system, but a core argument in favour of a change in this direction is that no matter what the total health care expenditure amounts to it can be more fairly and effectively used in a UHI system.

Conclusion

History shows that radical health care reform happens in a time of crisis and challenge. The NHS was introduced in the UK after the Second World War. The USA is planning major health reform now in a time of global recession. Eastern European countries after the fall of Communism developed universal health care when relatively poor circumstances prevailed.

As we approach the time when we will celebrate one hundred years of the independence gained in 1921, we in the Republic of Ireland might set ourselves the exciting and challenging goal of putting in place a system of universal and equitable health care.[14] We have the advantage of being able to take account of experiences elsewhere – of countries which have long had a universal health insurance system and of those which have adopted one relatively recently – so that we could 'avoid rather than imitate harmful features that have found their way into the [UHI] systems of other countries'.[15]

Strong and courageous leadership is required if Ireland is to develop a pathway to universal health care. I am confident that the people would respond and be inspired by the grand democratic goal of equal care for all citizens free at the point of need. Imagine an Ireland where the financial burden of illness was shared by all and where all would be assured of access to services on the basis of need, not income.

Notes

1. See A. Dale Tussing and Maev-Ann Wren, *How Ireland Cares: The Case for Health Care Reform,* Dublin: New Island, 2006, for a comprehensive analysis of the issues and problems in the Irish health care system.
2. Department of Health, *Shaping a Healthier Future: A Strategy for Effective Health Care in the 1990s,* Dublin: Stationery Office, 1994; Department of Health and Children, *Quality and Fairness: A Health System for You – Health Strategy,* Dublin: Stationery Office, 2001.
3. The entry level for the lower rate of the health levy (now 4 per cent) is €26,000 per annum; the threshold for the higher rate of 5 per cent was lowered from the previous level of €100,100 to the new level of €75,036 per annum in the April 2009 Supplementary Budget.
4. The funding of Irish health care is analysed in two reports published by the Adelaide Hospital Society: *Social Health Insurance: Options for Ireland* (2006) and *Social Health Insurance: Further Options for Ireland* (2008). Both reports were written by Stephen Thomas, Charles Normand and Samantha Smith. See: www.adelaide.ie
5. Stephen Thomas, Charles Normand and Samantha Smith, *Social Health Insurance: Options for Ireland*, Dublin: Adelaide Hospital Society, 2006, p. 13.
6. *Ibid*., p. 9.
7. Stephen Thomas, Charles Normand and Samantha Smith, *Social Health Insurance: Further Options for Ireland*, Dublin: Adelaide Hospital Society, 2008, p. 5.
8. Samantha Smith, *Equity in Health Care: A View from the Irish Health Care System*, Dublin: Adelaide Hospital Society, 2009 (An Adelaide Health Policy Brief), pp. 2–4.
9 *Ibid*., p. 5–6.
10. Anne Nolan and Brian Nolan, 'The Utilisation of GP Services', in Brian Nolan *et al* (eds.), *The Provision and Use of Health Services, Health Inequalities and Health and Social Gain,* Dublin: Economic and Social Research Institute, 2007; Dermot O'Reilly *et al*, 'Consultation Charges in Ireland Deter a Large Proportion of Patients from Seeing the GP: Results of a Cross-Sectional Survey', *The European Journal of General Practice,* Vol. 13, Issue 4, 2007, pp. 231–36.
11. The capacity problems are analysed in detail in Stephen Thomas, Charles Normand and Samantha Smith, *Social Health Insurance: Further Options for Ireland* (2008) and in a number of other published studies.
12. *Ibid*., pp. 20–27.
13. *Ibid*., p. 28.
14. See the joint policy paper of the Adelaide Hospital Society and the Jesuit Centre for Faith and Justice for a fresh articulation of the vision and values required: 'A health system which is centred upon the dignity of every human being, which treats body, mind and spirit in a holistic way, and which treats each person upon the basis of their need rather than their financial status.' (Adelaide Hospital Society and the Jesuit Centre for Faith and Justice, *The Irish Health Service: Vision, Values, Reality*, Dublin, June 2007; www.adelaide.ie and www.jcfj.ie)
15. Stephen Thomas, Charles Normand and Samantha Smith, *Social Health Insurance: Options for Ireland* (2006), p. 5.

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