THE ADELAIDE HOSPITAL SOCIETY

Policy Paper

Universal Health Insurance:
The Way Forward for Irish Healthcare

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April, 2010

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1. Introduction

1.1 The Adelaide Hospital Society has advocated fundamental reform of the way the Irish health system is financed over the last decade. We submitted this view prior to the launch of the Government's Health Strategy, Quality and Fairness, in 2001. In the intervening years there has been much structural reform of the administration of the Irish health system, in particular the establishment of the HSE in 2005, but little enough effective reform: the Irish health system remains grossly inequitable and the unfair 'two tier' system remains intact.

1.2 The Adelaide Hospital Society published Just Caring:Equity and Access in Healthcare-A Prescription for Change in 2005 setting out a comprehensive range of recommendations to address the embedded crisis in Irish healthcare. The key policy orientation underpinning these recommendations is that of **social solidarity**: we believe that, as citizens in a republic, we must all share the burden of illness and disease collectively and that all citizens must receive equal care and treatment upon the basis of their healthcare needs rather than their financial status or means.

In 2007 the Adelaide Hospital Society and the Jesuit Centre for Faith and Justice published a joint Policy Paper entitled The Irish Health Service: Vision, Values, Reality which set out a clear set of values and a vision for Irish healthcare and set these against the reality of inadequate capacity, privatisation and the continuing crisis-laden unjust health system experienced by so many Irish citizens. 2007 was the year when Susie Long courageously told her story of how the 'two tier' system and its inequality of provision cost her life: she died in October 2007.

1.3 The Vision

Our vision for the Irish health system is as follows:

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

1.4 The Importance of Values

The Adelaide Hospital Society believes that clarity about the values which determine health policy and which influence the implementation of health policy is crucial. Values provide direction in making choices in the design of our health care system: who gets care, which type of care is provided, who pays for care and how we pay for care; our values also shape the quality of caring as healthcare is fundamentally about human beings caring for other human beings. The values we espouse in healthcare are centred on justice, caring, patient and public participation in healthcare. We believe that, in respect of justice, the lack of equity in the present Irish health system leads to treating people differently in a way which is unnecessary, avoidable, unfair and unjust. In 2009 the Adelaide Hospital Society published an Adelaide Health Policy Brief prepared by Samantha Smith, Equity in Health Care: A View from the Irish Health Care System which demonstrated the lack of clarity concerning the value of 'equity' in the way the Irish health system is currently funded which has resulted in our unique 'two tier' system. Professor William Hsiao, the Harvard economist who has helped design healthcare systems for many countries, states that the primary decision in the development of a national healthcare system is a moral one: "Your ethics, your sense of justice, determine how you distribute goods and services, including healthcare – So the first question has to deal with a country's ethical values"[1] Reform of the financing of Irish healthcare is a moral imperative and if we believe that each person has an equal right to access appropriate healthcare then we are obliged to use the best evidence and knowledge available to us to design and implement a financial system that ensures this.

1.5 The Adelaide Hospital Society has commissioned a series of groundbreaking independent research reports to study whether and how a social insurance-based financing system (such as obtains widely in the European Union) would be feasible in Ireland, to examine the cost implications, to explore viable designs for a social insurance funding mechanism in Ireland and to consider the steps required to attain universal and equal access to healthcare for all.

The Adelaide Hospital Society commissioned the Centre for Policy and Management in Trinity College, Dublin to undertake these research studies because of its unique expertise in health economics and, in particular, the financing of health systems. Three key reports have been published as follows:

(i) Stephen Thomas, Charles Normand, Samantha Smith Social Health Insurance: Options for Ireland (Adelaide Hospital Society, 2006)

(ii) Stephen Thomas, Charles Normand, Samantha Smith Social Health Insurance: Further Options for Ireland (Adelaide Hospital Society, 2008)

(iii) Stephen Thomas, Padhraig Ryan, Charles Normand Effective Foundations for the Financing and Organisation of Social Health Insurance in Ireland (Adelaide Hospital Society, 2010).

1.6 These Reports provide a crucial evidence base for our policy proposals for the reform of the funding system of Irish healthcare which are set out below. In addition we draw upon the health policy studies which have been produced in other countries and the policy debates concerning the provision of universal healthcare notably in the United States of America. These proposals are made by the Adelaide Hospital Society on its own behalf having given consideration to the best available information. In recent years there has been a welcome and growing commitment to social health insurance as a mechanism to provide universal healthcare in Ireland. A number of political parties have produced their own policies which commit them to a social insurance-based financing system and to reform of the current arrangements. We earnestly hope that a broad political consensus may develop which will support the necessary steps to achieve for Irish citizens what is common for so many European Union countries: comprehensive care for every citizen based upon medical need rather than financial status.

2. *Present and Future Financing of Irish Healthcare*

2.1 Full descriptions of the present means of financing Irish healthcare are set out in the Reports referred to above. Currently we pay for our health system in three ways:

A. **Taxation** (including the health levy) contributes about 75 per cent of total health expenditure

B. **Out of Pocket payments** contribute about 15 per cent of total health expenditure

C. **Private Health Insurance** contributes about 10 per cent of total health expenditure with around 50% of the population paying this to supplement their care

This unique mix of public and private financing and provision of healthcare creates the 'two tier' system by facilitating faster access to health services by those who purchase private health insurance: financial means rather than medical need determines access. The need to reform radically the current system has become very evident. The current system is:

1. **unfair** to public patients
2. **not effective**: it 'rations' care creating long waiting lists
3. **grossly inefficient and very poor** at relating performance and outcomes to the financial allocations provided; indeed it rewards **not** treating patients in order to keep within 'rationed' allocations
4. **perverse** in the incentives it creates for those employed to provide care.
5. **involves** payment for GP services for non-medical card holders, inhibiting proper utilisation of primary care – this is counter productive in health prevention terms and leads to inappropriate use of accident & emergency services.
6. **gives poor value** to those paying supplementary private health insurance despite rising premiums and requires out-of-pocket payments for basic care at primary care level for everyone except medical card holders.

2.2 The Future Financing System: Social Health Insurance

In a Social Health Insurance funded health system the basic underlying principle which applies is 'access on the basis of clinical need, payment on the basis of income or wealth'. This 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. In such a system all contribute to cover (insure against) the risks of all people in respect of their health care needs insofar as their income or wealth allows. In simple terms we collectively share the burden of illness and disease; no individual has to worry that they will be left out of care or suffer unequal access to care.

2.3 The Key Features of Social Health Insurance

There are wide variations in the way social health insurance (SHI) operates to finance healthcare in over twenty-seven very different countries. This reality provides an opportunity for Ireland to learn how best to design a SHI model to suit our own context. **There are key features which require to be embraced in Ireland:**

- All citizens are insured through the payment of a premium 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.
- The State pays or supplements the premium of those citizens who are on lower incomes and thereby **every** citizen is an insured patient with **equal access** to the health system.
- The premiums are paid to a fund (or funds) **separate** from the Exchequer or State funds raised by general taxation and are not, therefore, as subject to the annual 'ups and downs' of expenditure allocations made by Government from general taxation and receipts: this is vital for developing and maintaining health services especially given the recent macro-economic shocks experienced in Ireland and elsewhere.
- Care covered by social health insurance premiums may be delivered by public, private not for profit or private for profit healthcare providers on a 'level playing pitch'; indeed SHI systems in Europe contain a higher proportion of private providers than tax-based systems.
- There is a specified common basket or set of health services covered by the premium paid; typically these include free access to GP and primary care services including drugs and prescriptions; free acute hospital care and may additionally include long term care.
- 'The money follows the patient' – in other words the amount of revenue generated by hospitals and primary care centres is largely determined by the number of patients provided with treatment and care: providers, therefore, have a strong efficiency incentive to care for as many people as possible as effectively as possible: **quality becomes key.**

2.4 The Seven Potential Advantages of Social Health Insurance as a Funding Mechanism

(a) SHI enables the provision of a one-tier system of healthcare with access based upon medical need not income.

(b) SHI provides a means to provide in Ireland primary care services free at the point of usage for the entire population ending Ireland's unique out-of-pocket payments for GP services which are a barrier to effective healthcare.

(c) SHI puts the patient 'front and centre' for all health providers as the 'money follows the patient'; at present the patient is often 'last and back' in terms of health provision decisions.

(d) SHI is a **transparent** funding system: citizens see what they exactly are getting for their premiums.

(e) SHI combines the promotion of social solidarity with more accountable and efficient public service provision.

(f) SHI by separating a large element of health funding from the vagaries of annual Exchequer finances thereby creates more stability in healthcare financing and facilitates multi-annual planning of capacity and services.

(g) SHI promotes a necessary element of 'subsidiarity' in healthcare provision, thereby enabling providers to have the power as well as the responsibility for healthcare provision. This will dismantle the excessive administrative and bureaucratic centralisation which has developed since 2005 under the HSE in Ireland: by the design of contracting and payment systems efficiency gains and better models of care may be pursued.

2.5 SHI: A Mechanism not a Policy

There are potential disadvantages and dangers in adopting social health insurance as means

of funding healthcare: for example, SHI may be funded in a regressive fashion with the greater burden falling on the less well off or it might be administered in such a way that it contributes to higher costs if effective payment systems to providers are not implemented. Therefore the precise mechanisms to be adopted in Ireland must be based upon a clear expression of both values and policy objectives in order to turn the potential advantages outlined above into real advantages.

Social Health Insurance is a means to an end: policy needs to be set clearly and the system of SHI designed to achieve stated policy. If the policy objectives of equity, value for money and universal coverage are clearly established then the operational details of SHI can be specified to enable them to be achieved. Appropriate design and cost efficient management of SHI is crucial. There are capacity constraints in the Irish health care system, such as the supply of doctors, which require to be addressed regardless of what means we use to fund healthcare: therefore, all necessary future investments in healthcare do not arise simply from changing the financing system. They will need to be made in any event. There is indeed some evidence that universal healthcare using appropriate social insurance financing mechanisms lowers the costs of healthcare when compared with other funding methods[2] while greatly improving health outcomes. To achieve such a key result requires very careful attention to the design of the SHI system, and to the payment systems to providers in particular, so that there will be a deep and continuous impact on sustainable and systematic improvements in access to care, equity, quality of care, efficiency, and cost control.

The policy proposals set out below by the Adelaide Hospital Society are based upon our vision, values and clear policy goals in respect of equity and effectiveness; they are based upon the best evidence available as to the way forward for Irish healthcare.

3. *Road-map to achieve universal healthcare in Ireland*

3.1 **We are now at a crucial turning point in regard to the Irish health system.** Reform of the financing of the health system is the main lever to use to create a just and effective comprehensive health system. Increasing expenditure through taxation, facilitating privatisation and creating centralised administration have each been employed in the last decade and have each failed to create the quality of access and care for all citizens which Irish people need and deserve and which are commonplace in our fellow member states of the EU. **We must now plan for a radical reform sustained over a period of years with a clear national purpose: a health system that will compare favourably within the best of the European Union and will guarantee for all citizens access to quality care and treatment over their lives. We are able to draw upon lessons from other countries to shorten our road to success.**

3.2 We propose that the Oireachtas sets a **new national goal** to reform the financing of Irish healthcare by the introduction of mandatory social health insurance. We propose that a new **Social Health Insurance Authority,** with the **necessary legislative basis**, be established to oversee the design and planning of the steps necessary to attain universal healthcare using SHI. [Consideration may be given as to how the new Social Health Insurance Authority may subsume the current responsibilities of the Health Insurance Authority, established in 2001, which has responsibilities in respect of Ireland's private health insurance market. There will continue to be scope for private insurance over and above the socially insured common 'basket' of services.] At times of crisis we need political leadership and resolve to set the direction and to provide the necessary authority to achieve agreed policy goals in healthcare. It should be made clear that no interest vested in the benefits of the current maladapted funded system will be able to obstruct the provision for all our citizens of equal access to healthcare; as President Obama has stated "There is a moral imperative to reform of healthcare" given the injustice of the present system combined with its inefficiencies and ineffectiveness. Given the analysis by the Expert Group on the Financing and Resource Allocation in Healthcare, chaired by Professor Frances Ruane, and the other reports, such as those by the Adelaide Hospital Society, it is now urgent to move from **analysis to implementation, recognising of course, that this will be a process which**

will require careful planning and staging, to achieve the stated objectives. Providing a legislative mandate for the proposed authority will ensure this will proceed and will avoid any vested interests, that have a stake in the current dysfunctional system being empowered to block change.

3.3 We propose that the **Social Health Insurance Authority** be charged with laying the effective foundation for the financing and organisation of Social Health Insurance in Ireland over a period of years. A key responsibility of this specialised body would be to secure in the Irish context the right technical design for SHI in Ireland. It would report, through the Minister for Health & Children, to the Oireactas and be required to lay progress reports before the Oireactas as it works to achieve an effective system of universal healthcare through SHI. It would have a key developmental role in respect of any capacity constraints in healthcare provision working with a revitalised Department of Health and Children to produce a coherent medium and long-term strategic plan for Irish healthcare. The Authority should be governed by a small Board composed of those with the necessary international and national expertise in financing healthcare services, the provision of quality outcomes in healthcare and with some citizens representing the public interest. Public trust and confidence is essential as is national consensus about achieving the great goal of equal access to quality services for every citizen.

3.4 We propose that in the initial phase that **a single Social Health Insurance Fund be established. In relation to the governance of both the Social Health Insurance Authority and the single Social Health Insurance Fund a very significant opportunity is provided for public and patient participation and it is to the extent that this opportunity is taken by Government that public confidence will be built into the transition to universal healthcare**. International evidence is clear that extreme caution is required when considering introducing competition between SHI Funds in a SHI system. Later, when we have SHI safely established consideration might be given to increasing the number of funds. The most effective way to develop a single Social Health Insurance Fund would be as a not-for-profit national social health insurance fund. This would give the public confidence that the Fund is oriented primarily around the patient and care rather than profit. However it would be possible to have private firms compete to run the not-for-profit SHI Fund and paid in accordance to their success in meeting specified targets. The prospect of competition for the contract periodically would incentivise performance. Establishing a single SHI Fund, in the first phase, would minimise administration costs, avoid risk equalisation systems, and minimise the disruption. Using competing private health insurance funds in a system where it is mandatory for every citizen to have health insurance for a common basket of services may have a place in a very mature health insurance system and culture as in The Netherlands (although it is too early to judge the results there of the 2006 reforms) but in the Irish context now it is critical to obtain the benefits of a single-payer system and to avoid the very costly transaction costs attached to multiple private funds. The evidence to date suggests that private health insurance companies do not yield greater efficiency and cost control. Rather they add to costs and layers of administration for both providers and governments: fractured payment systems mean multiple claims databases and tend to subvert quality improvement efforts while adding to costs. For example the multiplicity of insurers in the USA means that US hospitals spend more than twice as much on billing and administration as do hospitals in Canada (where there is a single payer system).

3.5 As clarity about decision making is vital, we propose that governmental responsibilities in respect of the development of the Irish health care system be **specified in legislation**. The role of the **Minister for Health** and the **Department of Health and Children** in this context ought to be:

1. To set overall health policy goals
2. To create, in conjunction with the new Social Health Insurance Authority, the policy framework for SHI and to ensure that the necessary implementation steps are taken.
3. To monitor the performance of the Social Health Insurance Fund and providers by establishing the necessary regulatory framework and institutions. It is the role of Government to decide, on behalf of citizens the 'common basket' of health services covered by health insurance.

4. To monitor, in conjunction with the Health Information and Quality Authority (HIQA) the quality of care; we envisage a significantly augmented role for a clearly independent, well resourced and expert body like HIQA in a SHI system.
5. To ensure effective development of health related services which are not funded through social health insurance such as, population health actions, public health and medical and nursing education and research and other key areas of health development.
6. To oversee the transition from the current funding and administrative arrangements towards the full introduction of the SHI funded system. In particular, it is vital that Government, through the Department of Health and Children, address the capacity constraints which have been identified in our health system in a number of key reports[3].

We recommend that the staffing and expertise in the Department of Health and Children be developed to fulfil the State's key ongoing responsibilities in healthcare.

3.6 Benefit Package: 'Common Basket'

Defining the 'common basket' or set of services to be provided in a SHI funded system is not a one-off process. The Adelaide Hospital Society proposes that the new Social Health Insurance Authority engage in a major public consultative exercise on the options (setting out the possible costs of each option) for the 'common basket'; this will engage the public in building it's own national health service while educating citizens about the costs and benefits and having dialogue about what people are prepared to pay into an ear-marked SHI Fund for services to which they would be entitled free at the point of use. The development of the 'common basket will need continuous and progressive review by Government which would have the ultimate responsibility to decide what specific benefits are provided for citizens as advised by the Social Health Insurance Authority from time to time.

We propose that the initial 'basket' of services gives priority to primary care provision and so should include free GP access at the point of need and coverage of medicines prescribed. It should also include acute hospital care and treatment.

3.7 Paying for Services: A Framework for Payment Reform

It will be the responsibility of the Single Insurance Fund, supervised by the Social Health Insurance Authority, to devise the mix of payment systems for patient services to providers; such payment systems may include single annual payment (for example, Emergency Departments) and fees per case (for example, acute care). It has been established that efficiency gains of up to at least 10 per cent reduction in costs are achievable through case-based hospital contracting, administrative savings through rationalisation and/or competition and through other means. There must be a strong mandate to achieve efficiency gains in order to generate surplus resources to improve and develop healthcare.

The payment systems need to be designed to have a key incentivising role in developing 'integrated health' so that providers are encouraged to treat in the optimum context for patient care : for example, to employ new models of chronic disease management at primary and community care levels. Changes in the organisation of health delivery systems will be driven by the need to respond collectively to new payment methods. Waste resulting from unnecessary and less satisfactory care must be eliminated from the health system. The concept of 'bundling payments' to cover wholistic care over a specified period is one example of using the payment system to drive higher quality care at least cost. Using a single-payer system will facilitate the utilisation of payment systems to achieve better care at lower cost. The objectives which payment systems should be designed to achieve include:

- Strengthening and reinforcing primary and community care
- Promoting more accessible, co-ordinated, patient-centred care with a focus on health promotion and disease prevention and better chronic disease management.
- Achieving more effective, efficient, and integrated health care delivery by adopting more bundled payment approaches to paying for care over a period of time or for a duration of an illness, with rewards for quality, outcomes, and efficiency

The introduction of 'money follows the patient' payment will in itself be a radical advance on the current allocation of historically determined annual allocations to providers. Improvements in care and cost efficiencies

are mutually supportive and legitimate objectives. We support the shift required in health systems from a focus on high-cost, intensive medical interventions towards a high-value primary care provision combined with prevention and health promotion.

3.8 Funding bases for SHI in Ireland : A NEW COVENANT in public services

Equity considerations are primary in designing the model to use for paying for SHI in Ireland. It is vital that the model we design is **progressive**: that is, that the better off pay proportionately more than the less well off and that the overall level of taxes and SHI contributions should be planned together to ensure the desired pattern of progressivity. The research carried out on behalf of the Adelaide Hospital Society has demonstrated the financial feasibility of developing SHI in Ireland in a carefully planned and phased manner. Naturally everyone wants to know what a SHI system of universal care would cost; the answer is: it depends upon what the people would like to insure themselves against in the 'common basket' of health services. **For the initial 'common basket' we have proposed above – free GP care and medicines and free acute care and treatment- at 2007 figures the percentage of GDP spent on Irish healthcare remains the same at 7.6 per cent with 10 per cent efficiency gains (a reasonable assumption) and rises to 7.83 percent with zero efficiency gains.** In other words, this 'common basket' would not require any significant extra spending of national wealth but does require a significant change in the flow of healthcare funding. Those citizens who currently contribute their taxes to help fund healthcare and who pay out-of pocket payments for primary care as well as rising private health insurance premiums need to be convinced of the significant advantage it would be to them to have guaranteed access to essential health services upon payment of a single premium. The reduction in their general tax and having no need to pay out-of-pocket payments or to purchase private health insurance would represent for them a much improved system. It would be a better situation, indeed, for all citizens. **There are, moreover, a range of health funding reform options to be considered in the context of (and in the resolution of) the current fiscal financial crisis.** SHI may be funded through a variety of sources, including premiums (in lieu of taxation), earmarking of 'sin' taxation (for example, tobacco, alcohol) for health, and using other sources. If a mix were adopted the premiums would be lower than if all costs of the 'common basket' were met by the premiums alone. The Government will need to contribute to the Social Health Insurance Fund the premiums for those on incomes below a certain threshold. In the light of the on-going fiscal crisis in Ireland it is imperative to reform the financing of our healthcare system if it is to be sustainable in the years ahead and if it is to provide the care services required and to cope with future needs. Continuing to raise funds for health through general taxation and to allocate resources in the current fashion is a recipe for declining health resources, increased rationing and waiting lists, inappropriate care and extensive and continuing waste of resources and poor value for money. There must be a **new covenant** developed between the citizen, who is entitled and has a human right to appropriate and timely healthcare, and the providers of care in order **to link in a transparent way the citizens' funding for healthcare with the care services they receive.** This will set a headline, indeed, for public service reform generally in Ireland. Such a covenant will over time restore public trust in the Irish healthcare system and will facilitate the public consent to the level of funding requested for an adequate level ofservices; providers will be challenged to provide such a people-centred service as their revenues will accrue from the number of patients they treat satisfactorily.

In developing the funding bases for social health insurance in Ireland it is important to apply what has been learned by the experiences of the countries that use a version of universal health insurance. **For example it has been learned that co-payments and deductibles discourage preventive care, decrease the use of essential care, are expensive to administer, and especially endanger the most vulnerable patients- the poor and those with chronic illnesses**[4] **The international evidence is clear that in countries where the healthcare system removes for everyone the great fear of the financial burden of illness, the people value it highly and are prepared to contribute to its costs in proportion to their means - and, if necessary, at a higher level than is acceptable in a general tax - funded system.**

3.9 Funding Choices and estimates of the impact on households

As outlined above there are a number of options to be considered in relation to financing SHI in Ireland. One promising option to consider is the 'mixed bag' option whereby social health insurance is funded through a variety of sources- a 'mix' of funding bases which would reduce the reliance on payroll deductions. The burden is spread across different modes of taxation – 'sin' taxes (alcohol and tobacco), a carbon tax and/or property taxes in addition to earmarked payroll deductions. For example, hypothecating excise from alcohol and tobacco for the health services could be expected to raise €2.2 billion per annum. It would be possible to raise over 30% of total SHI funding from a 'mix' of sources as outlined in Thomas et al in their Report, Effective Foundations for the Financing and Organisation of Social Health Insurance in Ireland (Thomas et al, 2010)

However, assume that Ireland were to opt for a 'Pure' model, that is, funding SHI entirely by earmarked deductions on income over the threshold amounts for income tax. Assume also that Ireland wishes to fund a 'levelling up' of what SHI provides to upgrade the access to health care services for the worse-off to that of the best-off eg access as for those with supplementary health insurance and free GP and medicines. If there are no efficiency gains there is an estimated 6.6 percentage point increase on current payroll deduction levels and with a 10% efficiency gain this is reduced to 3.1 percentage points. For a married couple on a combined income of € 70,000 per annum the additional annual amount would be either €2818 or €235 per month or with efficiency gains €1314 or €109 per month. For a single person on €25,000 per annum the additional spending would be €445 per annum or €37 per month or €207 per annum or approx €17 per month.

Obviously the above gives an estimate of the maximum extra cost for the best 'common basket'. The Adelaide Hospital Society are suggesting free GP and drugs and free hospital care and that a 'mixed bag' approach be considered in order to reduce ear-marked deductions by way of premiums on income. Therefore the impact on selected households would vary with the choice of funding bases and the content of the 'common basket'.

Thomas et. al. point out that that with 10% efficiency gains the common basket the Adelaide Hospital Society suggests is affordable with no extra additional revenue expenditure. They also point out that efficiency gains lowering costs by 19% across the health care system would allow the introduction of the 'levelling up' option {upgrading the access to health care services for the worse- off to that of the best-off} with no additional spending. This underlines how critical it is to use payment systems that drive such gains. The impact of the proposed 'common basket' with no efficiency gains and using a 'pure' model of funding SHI amount to €7 per month for a single person earning €25,000 and €18 per month for a married couple with one earner on €45,000 per annum and €43 per month for a married couple with a combined income of €70,000 per annum. These estimates demonstrate that SHI is both feasible and that there are real choices to be made as to how it is funded in Ireland.

3.10 Information Technology: A 'Carte Vitale' for every person

Utilising information technology to ensure effective quality care and cost effective administration is a key element in transitioning the Irish health system towards a social insurance-based system of universal healthcare. The success of the 'carte vitale' in the French health system illustrates the advantage of this central administrative tool of French healthcare. The carte vitale – the 'vital card' or 'card of life' contains a patient's entire medical record and is the size of a credit card. It also facilitates the electronic payment systems used by the French. Such a card is used by every French citizen. This use of information technology creates major financial savings by reducing paper-based administrative overheads. It is a key part of a strategy to keep administrative costs low while providing better and easier access to timely care for every patient. The Adelaide Hospital Society proposes that such a card be developed and used in Ireland. It is important that due regard for patient privacy is assured with such a card as with every use of information technology. We should learn from France, Taiwan, Germany and other successful experiences with digital record-keeping for every citizen. A single-payer system – a unified system- makes it much easier to develop and use in the optimum fashion a 'carte vitale' for Ireland.

4. Conclusion

These outline proposals are designed to set significant signposts on the road to achieving universal healthcare based on a social health insurance funding system over the next five years. Such a significant change requires **vision and bold leadership**: the result will be of real benefit to every citizen now and in the future. Therefore, we should be determined to succeed as other countries have done in this great endeavour. Through careful planning and by building a national consensus a successful universal health insurance system can be developed which will lead to greatly reduced transaction costs and which will offer the information and tools to manage healthcare costs more efficiently in the future[5]. The details of how such a system can be structured and financed are, of course, critically important but they must not overshadow the overall goal - the provision of equal access to the best quality care for all our people. At this critical point in the country's development we need to hold out to people the hope and aspiration that they can share in a future where their healthcare will be guaranteed as to access and quality for each one when needed. No greater national goal might be sought.

Endnotes

1 Quoted in T.R. Reid The Healing of America A Global Quest for Better, Cheaper, and Fairer Health Care (The Penguin Press, New York, 2009) pp. 212-213.

2 For example see in relation to Taiwan, which introduced comprehensive health insurance in 1995, Jui-Fen Rachel Lu and William C. Hsiao " Does Universal Health Insurance Make Health Care Unaffordable? Lessons from Taiwan" Health Affairs Vol. 22 No 3 2003 pp 77-88 and K. Davis A.T. Huang " Learning from Taiwan: Experience with Universal Health Insurance" Annals of Internal Medicine Vol. 148 No 4, 2008 pp 313-314; see also the detailed studies by the Commonwealth Fund based in New York especially the Commission on a High Performance System accessible at www.commonwealthfund.org and , in particular, S. Guterman, K. Davis, C. Schoen, and K. Stremikis , Reforming Provider Payment: Essential Building Block for Health Reform (Commision on a High Performance Health System, The Commonwealth FUnd, March, 2009)

3 For example, Richard Layte et. al. Projecting the impact of Demographic Change on the Demand for and Delivery of Healthcare in Ireland. Dublin ESRI, 2009

4 See, for example, M.E. Rasell 'Cost-sharing in health insurance- a re-examination' New England Journal of Medicine Vol. 332, pp1164-1168.

5 Alex Preker, a leading health economist at the World Bank came to this conclusion for his research into OECD countries; universal healthcare led to cost containment, not cost explosion , see A.S. Preker " The Introduction of Universal Access to Health Care in the OECD: Lessons for Developing Countries" in Achieving Universal Coverage of Health Care eds. S. Nitagyarumphong and A. Mills (Ministry of Public Health, Bangkok, 1998) pp 103-124.

THE ADELAIDE HOSPITAL SOCIETY

The Adelaide Hospital Society,
The Adelaide and Meath Hospital,
Tallaght, Dublin 24

Tel: (01) 414 2071 Fax: (01) 414 2070
Email: roisin@adelaide.ie
www.adelaide.ie