



## Preface:

In May 2005 The Adelaide Hospital Society published *JUST CARING Equity & Access in Healthcare A Prescription for Change*. In that Adelaide Hospital Society Policy Paper, a range of recommendations were made to address the continuing crisis in Irish healthcare particularly the gross inequities and unequal access experienced by citizens in our health system.

The key policy orientation underpinning these recommendations is that of SOCIAL SOLIDARITY. The fundamental concept for public policy aimed at addressing inequity and unfair access must be a public consensus about the degree of social solidarity required in financing health services; we believe this ought to mean social and political acceptance of the value that all citizens must receive equal care and treatment upon the basis of their healthcare needs rather than their financial means.

In order to make explicit the detailed financial implications of social solidarity, the Adelaide Hospital Society commissioned this study *SOCIAL HEALTH INSURANCE: OPTIONS FOR IRELAND* to explore the relevance and applicability of social health insurance in the Irish context given the prevalence of its application in other European Union countries. We believe that this is a ground-breaking study which for the first time provides reliable estimates of the cost of equity in Irish healthcare and sets out options for all citizens to consider. We are most grateful to Professor Charles Normand, Dr. Stephen Thomas, and Ms. Samantha Smith, Health Policy and Management, Trinity College, Dublin, for preparing this land-mark study.

The Adelaide Hospital Society is pleased to publish this study as prepared independently by the authors as a contribution to advancing the healthcare of all Irish people. We will separately make a policy contribution from the Society to the options set out in this study. We look forward to other responses from political parties and other interested organisations when they have studied *SOCIAL HEALTH INSURANCE: OPTIONS FOR IRELAND*. There can hardly be a more important issue than that of seeking to ensure fair and equal access and treatment based upon medical need for all our people as soon as possible.

Professor Ian Graham,  
President

Professor Tom O'Dowd,  
Chair, Health Policy Committee

Dr. David Moore,  
Chairman

Dr. Fergus O'Ferrall,  
Director.



THE ADELAIDE HOSPITAL SOCIETY

**Adelaide & Meath Hospital Tallaght Dublin 24**

Tel: (01) 414 2071/414 2072

Fax: (01) 414 2070

Email: [info@adelaide.ie](mailto:info@adelaide.ie)

Web: [www.adelaide.ie](http://www.adelaide.ie)

## Executive Summary

### Background

There are problems that can be largely solved by universal social health insurance (SHI), problems where SHI can provide a facilitating environment, and problems where SHI is unlikely to make much difference. To understand the potential of SHI to improve the performance of the Irish health system we need to be clear about the current problems and how these would be alleviated by changes to the main system of financing health services. The potential benefits of SHI are:

- increased resources by increasing transparency and thus the acceptability to the population of increased payments;
- improved performance of the system reforms in the payment systems and related incentives can result in better access and efficiency;
- greater stability in financing – since decisions are removed from the general government budget process;

Nevertheless, SHI also brings with it risks, including potentially higher transaction costs (due to the parallel structures of taxation and social insurance), inequities (resulting from contribution systems that may be less progressive than taxation) and harmful macroeconomic effects if the burden of contributions falls too heavily on the employed. Consequently, introducing SHI only makes sense if the problems in the system include insufficient funding, poor performance, low public acceptability of the funding system and inappropriate incentives to providers.

### The Case for Change

The Irish healthcare system is unusual in that there is no subsidy for access to GP services for the majority of the population while a high proportion of the population has supplementary private medical insurance, which is subsidised. Further, a lack of transparency in the health financing system in Ireland has perpetuated inequities and inefficiencies. Current financial incentives and flows of subsidisation provoke uneven access to care for the medical card holders, the privately insured, and the non-covered groups in the population. Those on very low incomes are winners, but those on fairly low incomes face full or near full cost charges for primary care. Those with private medical insurance are subsidised by tax relief on premia and less than full cost charges for private care in public hospitals. The system of 'community rating' in the private medical insurance has inter alia the perverse effect of transferring funds from any young low income members to those who are on average richer, thereby being a serious disincentive to join for young, generally healthy people with low incomes.

### Potential models of SHI

SHI has the potential to improve significantly both the transparency of the current health system and its performance in terms of equity and efficiency. In this report, four alternative designs are developed to move Ireland toward these objectives. All are to be financed solely through the contributions of members, with government providing start-up investment. The four models are:

- Levelling up access and quality of all services (the "Rolls Royce" option) – This gives medical cards to all the population and effectively extends the benefits of private supplementary hospital insurance to all (including private/semi-private hospital beds and access to consultants);
- The Priority PHC model – This extends medical card coverage to all the population while removing some of the barriers to care for hospital services faced by the uncovered population;
- The Priority Hospital model – This focuses on extending hospital insurance cover across the population and lowering GP access charges to those without medical cards; and
- Making only small improvements in access (the "Mini" model) – This reduces the financial barriers to access at hospitals for the uninsured and substantially lowers the GP attendance fees for the population without medical cards.

These models can also be seen as stages in a developmental process.

The additional costs for implementing the SHI options range from €2.1 billion for the Rolls Royce option to €380 million for the Mini, in 2004 prices. Such costs can be reduced through efficiency gains associated with the current move toward case-based payments in hospitals.

### Principles and Burden of Financing

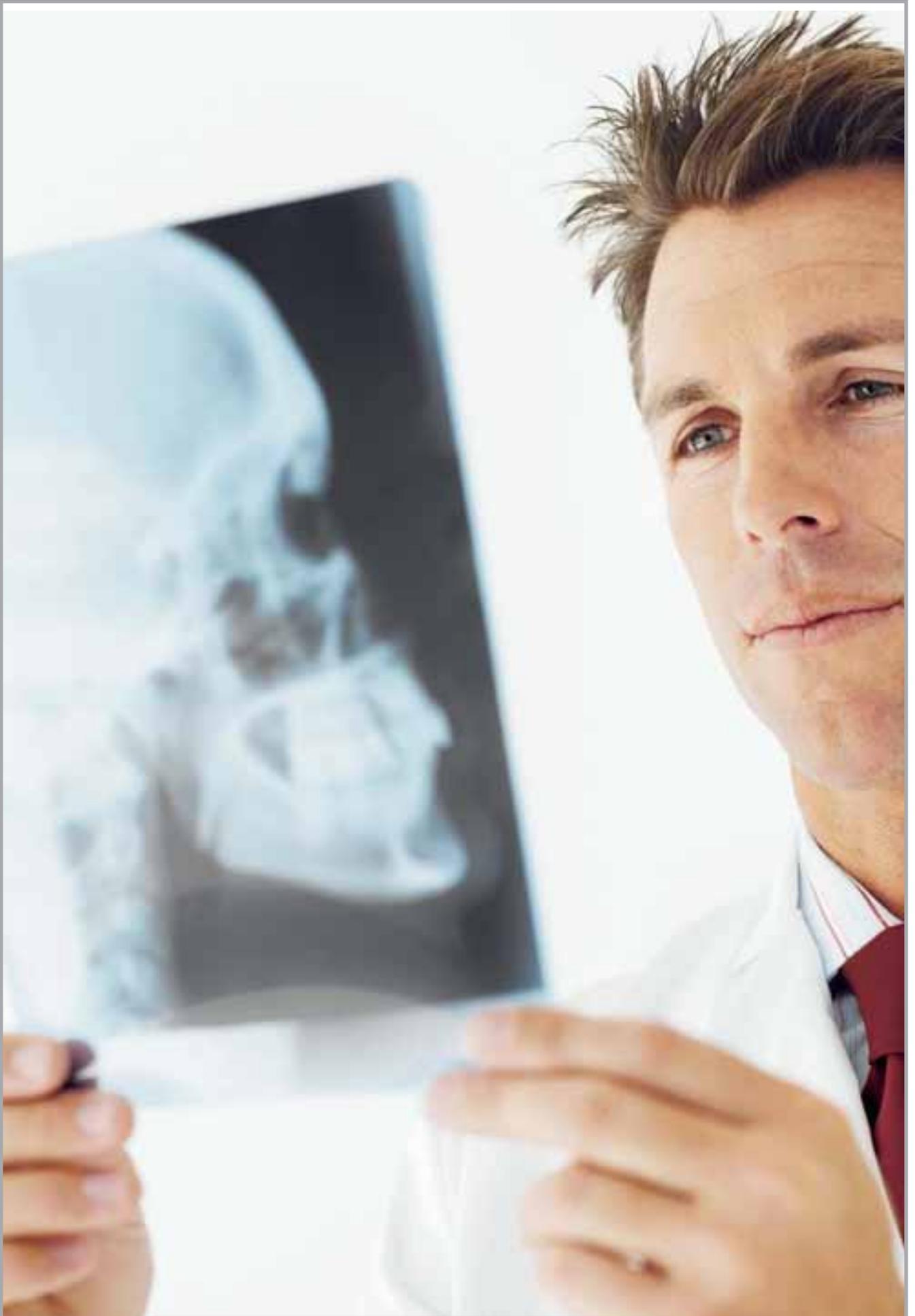
Several principles undergird the proposed financing of these SHI options. First, the financing arrangements must not harm those on relatively low incomes. Second, there is no upper limit on contributions by the rich. Third, members pay all costs associated with the scheme, to help boost transparency and preserve simplicity. This means that a substantial portion of income that currently goes to the general taxation system would instead be paid into an SHI fund. Members would pay quite high premia into the SHI fund while also getting a tax rebate and possibly also not purchasing private insurance. The additional payments for the options would range from 6.0% of taxable income for the Rolls Royce option to only 2.5% for the priority PHC option and 1.1% for the Mini. With efficiency gains, these rates would reduce so that the Mini option pays for itself and the priority PHC option costs only an additional 1.3% of taxable income.

### Implementation and Context

Nevertheless, any preferred design of SHI option can only be pursued with reference to a broader context. In planning SHI implementation, it is vital that due care is taken to understand and work with appropriate stakeholders, create a facilitating legal and administrative environment, remove supply-side bottlenecks in the public hospital sector and ensure that the overall tax and contribution burden is structured so as to impinge least on economic performance.



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## Chapter 1: Introduction

### 1. What is the Problem?

There is a widespread belief that the Irish Healthcare system is in crisis, especially in the provision of emergency services. There has also been serious discontent over the delays (and sometimes the effective barriers) to access to elective treatments. The health system is currently undergoing a major programme of reforms, focussing particularly on the structures of management and finance. While it is hoped that this reform programme will eventually improve the delivery of services, in itself it does little to alter the basic structures of who pays, what they pay, and what they are entitled to. The values underlying the current health strategy and reforms make it clear that the services should be based on fairness, but there are no significant levers to make finance and access more equitable. Further, the lack of transparency of funding flows in the health system has meant that inequities and inefficient subsidies have lain hidden (as will be discussed in Chapter 2). This has compromised the performance of the Irish health system against established criteria, such as fairness of financial contribution and appropriate access to services (Murray and Frenk, 2000).

It would of course be feasible to reform healthcare financing, and the associated provision, without radical change in the structures. This should be considered seriously. However, the focus of this report is on the feasibility and desirability of a moving to a system of universal social health insurance. Drawing on experience in other countries, this report looks at the likely effects of such a change, and the necessary steps. Yet it also focuses on specifying the underlying purpose. Social Health Insurance (SHI) is not a policy, but a mechanism that can, through greater clarity and transparency, allow policy objectives to be more easily met. The models of SHI discussed here are pure in the sense that they aim to maximise the advantages of the approach. No system is currently like that, largely because their evolution has involved many special arrangements and compromises that reduce the efficiency and equity of the system. The approach taken is to avoid rather than imitate harmful features that have found their way into SHI systems in other countries.

### 2. Terms of Reference

While there has been some discussion in political debate about a social insurance model, this has been hampered by a lack of clarity about the options and their strengths and weaknesses. Furthermore, while new financing arrangements have the potential to improve equity they will also bring fresh demand on the system which can only be realised by enhancing capacity, with additional facilities and expanded services and/or greatly increased efficiency in the use of existing capacity.

To help fill this knowledge gap and explore a way forward, the current study has been commissioned by the Adelaide Hospital Society. This scoping study explores the relevance and applicability of Social Health Insurance in the Irish context. The study follows the procedures outlined in the World Health Organisation and International Labour Office guidebook on Social Health Insurance (Normand and Weber 1994). It reviews the current policy context and priorities for the health system alongside options for SHI design and modes of financing. The authors also review system constraints and necessary steps in implementation to make SHI a useful reality.

In the remainder of this chapter the authors review the basic characteristics of SHI, and its application in different Western European contexts, taking note of its strengths and weaknesses.

### 3. The basic features of SHI

This section outlines the key features of SHI, and how it operates. (A fuller discussion of design and implementation issues and options is covered in Chapters 3 and 5.) The underlying principles that define SHI are: the provision of access to care on the basis of need, and the payment for insurance on the basis of income or ability to pay. This contrasts with private insurance, which relates payment for insurance to the risk of the individual falling ill and excludes those not able to afford.

#### The characteristics of the basic model are:

- Insured persons pay a regular contribution based on income or wealth, and not on the cost of the services they are likely to use.
- Access to treatment and care is determined by clinical need and not ability to pay.
- Contributions to the social insurance fund are kept separate from other government mandated taxes and charges.
- The social insurance fund finances care on behalf of the insured persons, and care is delivered by public and private healthcare providers.

SHI funds are formally separate from general taxation, and may be organised and managed by autonomous organisations. Since SHI is separate from taxation and other publicly mandated systems, the income from contributions must cover the fees paid for the services to which members are entitled. However, it is common for SHI to be subsidised in two ways – from government subsidies directly to providers of care (such as grants for capital developments) and through government payment of subscription for people unable to pay for themselves.

In terms of contributions and entitlement to services, the basic model has much in common with tax finance although, despite the similarities, SHI has retained much of the tradition and rhetoric of insurance. In practice, the differences between SHI and tax financed systems are more significant for several reasons. First, the separate structures for collecting and managing funds tend to give the system greater transparency. Second, the fact that members are

insured, and access to care is dependent on contributions to the fund, can give the patient the status of a customer. Third, in order to keep the system in balance it is necessary to be more explicit about the range of services to which the contributor is entitled.

Other characteristics frequently found in SHI are listed below.

- Employers and employees both make contributions to SHI.

It is not clear who actually pays when the burden is shared between employers and employees. Economic theory would suggest that, at least to some extent, rising insurance contributions will lead to falling wages. The tax treatment of insurance contributions is also important. If contributions are tax-exempt, then it costs the same for employers to pay them as it does to increase wages and for employees to pay.

- Contributions made by government (or special funds) on behalf of those who are not in employment are usually (but not always) channelled through the health insurance fund.

In an SHI system there are always some people who cannot contribute directly, and people for whom government support is likely to be needed. If funding for these people is paid through the SHI fund, this has the advantage that all people get the same service, and there is less danger of the service for the poor becoming a poor service. However, as argued later in this report, there is no advantage of fees being paid by government for those who cannot afford to pay as compared to the full cost of SHI being paid by a higher level of contributions by those who can pay. Retaining SHI as a completely separate system of financing has major advantages in terms of transparency and acceptability.

- Employees and employers participate in management of the fund or funds.

Employers are typically interested in (and are often skilled at) encouraging efficiency and containing costs. If they share responsibility for management of SHI they will put pressure on SHI managers to be efficient. It may also be important for employers to feel some control if they are making significant financial contributions to SHI.

- There may be more than one SHI fund.

A single fund can provide a mechanism for commissioning services that helps to control costs and improve access to care (Maynard 1996). Conversely, allowing more than one fund can give an element of choice and competition. However, more than one fund also brings potential difficulties in ensuring equal access to care for all and can increase the costs of administration. When there is more than one fund, a system of "risk equalisation" is needed to compensate funds with more expensive members (i.e. members with greater healthcare needs).

- SHI is compulsory for most citizens.

SHI involves the support of the sicker and poorer by the fitter and richer in the population. By pooling risk across different individuals and population groups, SHI can increase the access of the poorest and neediest to healthcare (Abel-Smith and Rawal, 1994). This does not work if the richer people are allowed to opt out of SHI. Where there are government schemes for the poor who cannot afford SHI membership, they tend to provide lower quality services.

- Patients have choice of doctor and other healthcare providers.

SHI funds are mainly involved in funding of care; delivery of care is by public and private (for-profit and not-for-profit) providers. There is usually some choice of doctor or provider. However, cost control concerns often limit this to 'approved' providers.

#### **4. SHI in Western Europe** **Coverage of the population**

The SHI model applies in many countries in Central and Western Europe, and there is some diversity in the models used. Funding access to healthcare through SHI has its origins in Germany in the nineteenth century although in many countries it is only recently that full population coverage has been achieved (e.g. Belgium in 1998 and France in 2000).

However, in general, SHI in this region has provided something close to universal access to essential services, and has generally been associated with high quality, popular and relatively expensive provision of health care. Coverage does not necessarily mean insuring everybody for the same benefits. Belgium has a two tier-system for 88% of the population in the 'general regime' (with a comprehensive benefits package) and 12% in the 'regime for self-employed' (for whom the benefits package covers 'major' risks only).

SHI in most countries developed over a period of time, with increasing numbers of people provided with increasing levels of access to services. There are some useful lessons to be learned from looking at the experience of countries during the period of development. In Korea the first priority in developing SHI was to provide some cover to the whole population. The choice of coverage for everyone meant that the insurance provided for only around half of the costs of care. An unexpected effect was to exclude many poorer people from using services since the co-payments were unaffordable, so there was a de facto subsidy from the poor to the rich. Other approaches to SHI development have



opted for complete coverage to certain sections of the population. It is relatively easy to organise SHI for government employees and full-time staff of large organisations. It is more difficult when people are employed on a temporary basis or are self-employed. For initially pragmatic reasons the cover is therefore often developed first for formal sector employees.

### Objectives

It is important to be clear about the health policy goals against which the judgements on the performance of SHI are to be made. Historically, the development of SHI systems has usually been in response to concerns that inadequate resources were mobilised to support access to health services. There is some evidence that the separation of healthcare spending from other government mandated spending can be successful in increasing the level of funding for health services. People show higher satisfaction with health services in countries with SHI in comparison to mainly tax-funded systems. This may be because of the generally higher levels of funding provided, with a higher willingness to pay since contributions cannot be diverted to other government programmes.

Since the 1980s, SHI reforms have aimed to increase equity, efficiency and choice for insurees and to reduce employment costs. To an extent these objectives are incompatible and each country effectively has to compromise. For instance, by introducing transfers from private to statutory health insurance, the Dutch reforms aimed to improve equity and improve cost-containment but some middle-income groups now pay more. In Germany the main objectives were to increase choice, improving equity and increasing awareness of costs.

When comparing systems of tax funding and SHI, measures suggest that tax funding is slightly more progressive (i.e. the burden falls more on those with higher incomes) as compared to SHI (Wagstaff et al. 1999). There is no evidence that countries with more than one fund are much less equitable than those with a single fund. Equity is undermined by the exemption from membership of richer people, and this may explain the regressive funding in the Netherlands.

While policy goals differ, the following can be considered as appropriate criteria for evaluating dimensions of fairness and efficiency (Normand and Busse, 2002):

- Contributing to the system should be based on ability to pay; access should be based on need (vertical and horizontal equity).
- Services should be available for those who are likely to derive significant benefit from them.
- Priority should go to those services that are likely to achieve the greatest health gain from given resources.
- Costs should be minimised for any given level of services.
- Both contributors to the system and users of services should be satisfied with structures, processes and outcomes.

### SHI Funds

The number and size of funds vary widely. Austria, France and Luxembourg have comparatively few; for example, Luxembourg has nine funds that are defined mainly by occupation. The Netherlands has around 30 funds, and Germany has over 400. In recent years there have been attempts in several countries to encourage competition between the funds. However, the degree to which the multiple funds operate separately is limited, and they tend to combine in negotiation with providers of care.

The evidence is scant on the advantages or otherwise of competing SHI funds. Risk adjustment processes are complex and expensive, and administration costs are usually higher with multiple funds, and for competition to be useful it must improve efficiency in the delivery of care. There is evidence that a single main payer for care (a monopsony) lowers the costs of provision. It is important to understand that it is not SHI per se that affects efficiency so much as the structures of provision, the system of paying providers and the resulting incentives. In the experience of developing SHI in Central and Eastern Europe there is some evidence that transaction costs increased. The mergers of insurance funds in the Czech Republic was partly due to a search for economies of scale, and was partly to reduce costs of operating contracts and agreements. The choice of simple contracting arrangements in Germany is in part a response to the need to keep costs down, although it will be interesting to see the effects of the current trend towards increasing competition between funds.

### Contributions

Contributions are mainly based on wages and are shared between employers and employees in all Western European countries with SHI. However, there are differences in the patterns of contributions in terms of income, the split between employers and employees, the level at which there is a ceiling on contributions and the extent to which non-wage income is included.

The contribution rate is uniform for all insurees regardless of the sickness fund and membership status in Belgium, France, Luxembourg and the Netherlands (prior to the recent reforms). In Austria, rates vary between 6.4% and 9.1% according to employment status but, within a given employment status, not between funds. In Germany, on the other hand, the contribution rates differ among funds but not by employment status. The employer:employee split is 50:50 in Austria, Belgium, Germany and Luxembourg. In France almost all is paid by employers (although employees pay a health tax) and in the Netherlands the split varies by scheme. There is a ceiling on contributions in Austria, Germany and Luxembourg) but not in Belgium and France.

There are contribution components in addition to the wage-based contribution in Belgium, France and the Netherlands. In Belgium the insured pay a small non-income-related per-capita premium on top of their contributions.

Most systems of SHI use current income as the main contribution base. This is in part due to their origins as employer-sponsored systems. Since income from employment has historically been a good proxy for ability to pay, this has been generally fair. However, there are several reasons why this narrow base is becoming less satisfactory. First, the trend is away from employment to self-employment. Second, more people have more than one job. Third, wealth affects ability to pay but is not taken into account. Fourth, unearned income is substantial in some countries.

The treatment of non-wage earners varies. Pensioners form the largest such group. In most cases pensioners pay the same rate on their pension as employees pay on their income. This amount may be split between the pensioner and the statutory pension fund (substituting for the employer) as in Germany and Luxembourg or it may be placed entirely on the pensioner as in the Netherlands. In Belgium pensioners pay only the employees' part of 3.55%; in Austria the contribution rate for pensioners is over 11%. In most cases pension funds pay some share of contribution for those who are retired.

Despite the independent status of SHI funds, in most countries the government can influence the level of contributions. In France contribution rates are negotiated between the government, representatives of employees and employers and the social security organisations themselves but government has the final say. In Germany and Luxembourg SHI funds themselves have the power to decide upon contribution rates. Their decision is, however, subject to governmental approval.

SHI funds collect contributions themselves in Austria and Germany. In Luxembourg the Association of Funds acts as a collection agency, while in Belgium the National Social Security Department collects the funds. A range of mechanisms exist for risk equalisation and the management of very expensive patients. In most cases the richer funds with the least sick patients try to resist the application of these devices.

#### **Tax subsidies to SHI**

The common assumption that SHI countries rely mainly on contributions to funds to finance their health systems has to be questioned. In international statistics on sources of healthcare funding it is often unclear whether expenditure through taxation includes tax subsidies to SHI funds or whether these are included as SHI expenditure. Austria and Switzerland, for example, finance a substantial part of hospital care directly through taxation (and have therefore relatively low figures of the expenditure share covered by SHI) while in the Netherlands, hospital care is exclusively financed by the SHI funds which in turn receive substantial subsidies from general taxation. In Austria funds receive no tax subsidies (except the farmers' fund). In most countries subsidies from tax are substantial. In France a recent innovation has been de facto subsidy from government when the debts of funds were taken over by government.

To estimate the degree to which countries rely on SHI contributions per se, based on wages, two factors have to be combined: the percentage of SHI income through wage-based contributions and the percentage of overall health expenditure covered through SHI. Based on such a calculation, Germany and the Netherlands are the only countries in Western Europe that cover more than 60% of total healthcare expenditure through wage-related contributions. In Belgium the level is around 38%.

#### **Rationing**

The experience of rationing and setting priorities in SHI systems is mixed. In Western European countries, at least in principle, there is little explicit rationing of access to care, despite a government-supported public debate on priorities in the Netherlands. In other SHI countries access is constrained, either by having a clearly defined benefits package, or through a high level of co-payments, as in Korea. There is no popular method of explicit rationing in healthcare. Unless resources are sufficient to satisfy all demands, some form of rationing is inevitable. A shift from tax finance to SHI does not change this. However, it may change who is responsible for choosing which services are provided, and may shift blame for constraints away from governments.

#### **5. Lessons for the Irish Context**

It is an important principle to learn from the experiences of others but not to copy systems that grew up in different settings. SHI in Western Europe has been very successful at meeting particular goals, especially in providing near-universal access to care. It has provided services that are acceptable to the public and that have a degree of solidarity. The successes of SHI are clear. The problems are mainly in the risk of cost escalation, excessive reliance on too narrow a contributions base, and potentially high costs of management and transactions.

In considering development of SHI it is important to be aware of the trade-offs that exist, between costs and the range of services available, between costs and degree of diversity and choice, and between competition and objectives of equity and low management costs. History and tradition have played very important parts in determining exactly how SHI operates. It has already been argued that there are many variants on the theme of SHI, and the performance of SHI systems may depend significantly on the detail of the chosen characteristics.

The main arguments in favour of SHI systems are: the potential to provide universal access to healthcare, the acceptability to the public, the transparency of financial flows, the potential to allow diversity and choice in provision (the long tradition that has allowed the development of mechanisms for ensuring some control of costs), and sound financial management. SHI systems tend to be associated with high levels of satisfaction in the population. To some extent SHI may make 'every patient a private patient'. Certainly SHI financing has been associated with attitudes to patients that treat them as valued customers and not simply a nuisance.



The potential problems with SHI are the risk of cost escalation, potentially high management and transaction costs (especially when patients have free choice of provider), and the need for good accountability. There is also a risk that SHI is too dependent on the payroll for contributions, at a time when the proportion of people with permanent jobs in large organisations is falling.

Most SHI systems have significant regulation by government, and systems vary from those that are close to being hypothecated taxes to those where the independent funds are only loosely supervised by government. As shown, many systems have some tax-financed payments by government (not all of which are visible and fully acknowledged), and in others there is an element of government guarantee of any debts. SHI countries typically have higher spending on health than those that use tax finance, and this is probably due in part to the greater transparency of financial flows, and the acceptability of funding for healthcare. Competition for provision of services is common, but it is only recently that serious consideration has been given to the development of competition for collecting and managing the funds. It remains to be seen whether market forces can play a useful role in forcing costs down while avoiding problems of inequity and high transaction costs.

## **6. Structure of Report**

This chapter has highlighted the basic features of SHI along with a review of its application in other Western European contexts. The next chapter reviews the Irish context for health financing and provision, noting the key features of the health system and the challenges facing policy makers. Chapter 3 goes on to explore the options for SHI design that would be most relevant for the current challenges and priorities in the Irish healthcare system. Four possible scenarios for SHI to move the Irish healthcare system toward policy objectives are set out in Chapter 4, which also reviews the resource implications of these scenarios, with and without efficiency gains. Chapter 5 explores the financing of these options while Chapter 6 deals with the issues of transition and implementation, noting the institutional, stakeholder and capacity bottlenecks which currently exist. The substantial costs of transition are noted. Finally Chapter 7 presents conclusions and area for further research.





## Chapter 2: Financing and Delivery of Healthcare in Ireland

This chapter explores in detail current and historical financing patterns of the Irish healthcare system. It also investigates public/private linkages and subsidies, and reviews the equity of financing and access to services for different segments of the population. By bringing to light such data, this chapter illuminates the structural weaknesses of the current Irish healthcare system in relation to key policy objectives and performance criteria. This provides a vital backdrop for considering SHI as a mechanism to implement policy.

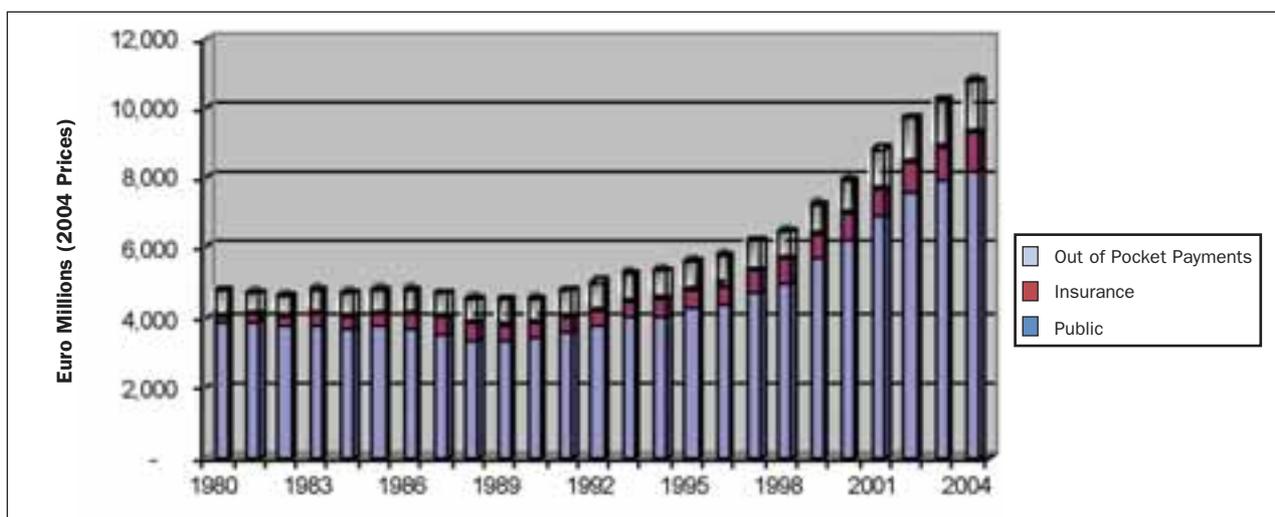
### 1. Financing Structure

#### Health Financing Trends and Composition

Ireland has experienced remarkable growth in the financing of its health system in recent years, as can be seen in Diagram 2.1. The expansion in funding was particularly strong from the mid to late 1990s to 2004 as the economy boomed. Indeed, the average annual growth rate in overall health financing between 1998 and 2004 was 9% after taking general inflation into account.

This was in stark contrast to the prior low levels of funding of the health sector, especially in the late 1980s, when financing fell in real terms. Indeed, the share of non-capital public health expenditure in GNP declined over the 1980s in line with falling public expenditure. While this share started to increase again in the 1990s, the substantial increases in health funding were subsequently overshadowed by the economic growth and the share of health expenditure in GNP fell over the much of the 1990s.

**Diagram 2.1: Non-Capital Health Financing in Ireland by source (1980–2004)**



Source: Derived from (Wiley 2005)

The Irish health system is financed by a mix of public and private sources. Diagram 2.1 shows the total non-capital health financing by public and private sources for selected years. While the proportions of public and private financing are relatively stable over the years, it is clear that public sources are the main financing mechanism. Public funding accounted for over 75% of total non-capital health spending in 2004, and this is primarily from general taxation. (A small amount of taxation is earmarked specifically to health in the form of a 2% health levy and this has relevance for any prospective Social Health Insurance mechanism, as will be seen in later in the report.)

While private health funding has grown substantially in recent years, at 9% per annum in constant prices between 1998 and 2004, it contributes a relatively small share of overall health financing, at 24% in 2004. Private health funding has two components. The first is direct out-of-pocket payments by households which includes spending on GP and other professionals' fees (e.g. dentists, opticians etc.), outlays on medicines (net of drug refunds from the government), other medical equipment and services, and net hospital charges. The second is the premia to private health insurance companies. Despite the significant coverage of supplementary private health insurance, to over 50% of the population in 2005, see Diagram 2.3, the revenues associated with this funding mechanism are surprisingly small, at only 10% of total health financing in 2004.

#### International Comparisons

Comparison with other countries is complicated. Public health expenditure in Ireland funds a range of social services that in an international context are not categorised as health expenditure (see Diagram 2.2). Adjusting for non-health expenditure, public current health spending per capita increased from 60% of the EU average in the 1960s to 94-95% of the average in current years (Tussing and Wren, 2006). Thus, despite the strong growth in public expenditure in the 1990s, Irish per-capita expenditure is still low relative to the EU average and might be even lower if further deductions are made for non-health specific programmes (Tussing and Wren, 2006).

By contrast, public capital health expenditure (not adjusted for social projects) exceeds the EU per capita average by over 200% (Tussing and Wren, 2006). Nevertheless, such high levels are needed to replace/upgrade depreciated health infrastructure and compensate for the lack of investment in previous decades. Public capital expenditure reached a low of 38% of the EU per capita average in 1990 and remained below the EU average until the mid-1990s (Tussing and Wren, 2006). Despite the large recent investment it is apparent that the healthcare system still lacks appropriate infrastructure (Commission on Financial Management and Control Systems in the Health Service, 2003).

A mix of public and private sources of financing is found in all health systems around the world (McPake, Kumaranayake et al. 2002). The relative contributions of these sources vary and countries can be grouped into those that are mainly public-financed, and those that have higher proportions of private financing. Ireland is part of the group of countries with predominantly tax-financed health systems, which also includes the UK, Finland, Denmark and Italy (Dixon and Mossialos, 2002). The group of countries with high proportions of social insurance funding includes the Netherlands, France and Germany. However, as noted earlier, some of these systems are supported by substantial tax-based subsidies by the government. At the other extreme, a smaller number of countries rely on high proportions of private sources (private health insurance, out-of-pocket expenditures) to fund the health system, including the US, Switzerland, South Africa, Brazil (McPake, Kumaranayake et al. 2002).

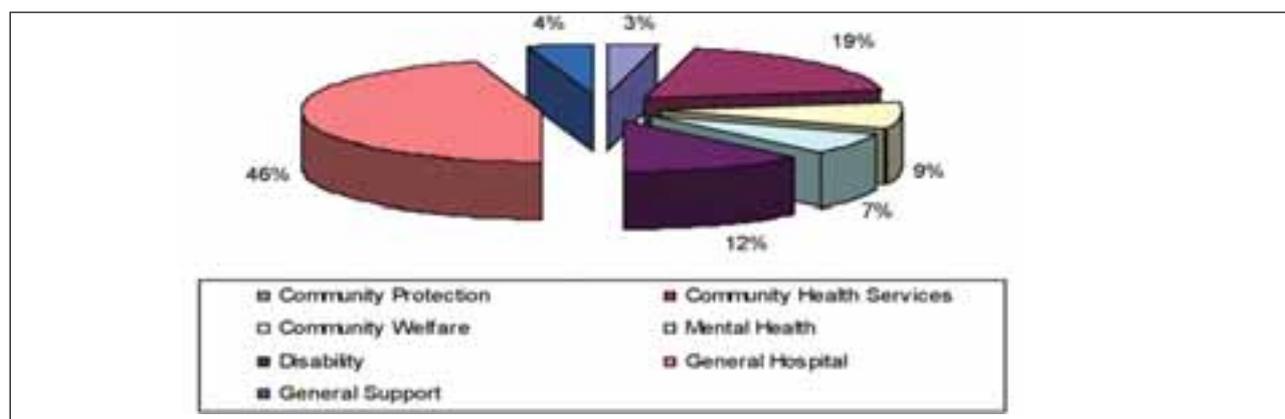
Predominantly tax-financed health systems tend to have the lowest levels of per capita health expenditure, followed by social insurance systems. Systems with large proportions of private financing show the highest levels of per-capita health expenditure relative to other countries. There is no conclusive evidence that this type of health system has a direct causative effect on health expenditure. Nevertheless, it is widely believed that there is a strong correlation between tax-financing and expenditure control (McPake, Kumaranayake et al. 2002). The key concern about tax-financed systems is that they underfund services. This has been the case in the Irish context, particularly in relation to investment in health infrastructure. In contrast, in social insurance based countries, key concerns are about cost containment and efficiency. These have been the driving factors behind a number of recent reforms (Saltman, 2004).

### Public Health Programmes

The non-capital public health budget is allocated via the Health Services Executive (and previously by the Dept. of Health and Children and Health Boards) to hospital, primary, and community health services (including mental health, disability services etc.). Acute hospitals command the highest proportion of public health resources although their share has slightly declined, from 54% of total non-capital public expenditure in 1980 to 48% in 2002 (Wiley, 2005). Funding of primary healthcare is relatively low with only 19% of the non-capital budget going to community health services. Indeed, primary care is predominantly funded by out-of-pocket payments from households. This is arguably both an inefficient and inequitable way to fund primary services.

Diagram 2.2 shows the breakdown of public non-capital expenditure by programme in 2004<sup>a</sup>. As noted earlier, public healthcare funding in Ireland includes welfare-related expenditure. Over half the additional money invested in health services in the latter half of the 1990s was directed to continuing care services, including services for people with disabilities, older people and children (DoHC 2001). Hence, the growth in the actual funding of healthcare related activities in the public sector, as shown in Diagram 2.1 is overstated, because of the substantial increase in funding of welfare activities.

**Diagram 2.2: Breakdown of Gross Non-Capital Public Health Expenditure in Ireland 2004 by percentage**



Source: (Dept. of Finance 2004)

### Entitlement Categories to Public Healthcare

Eligibility for public health services in Ireland has varied over time and there are now two broad categories of entitlement. It is worth exploring these to consider the equity of the current health system.

Individuals in Category I are eligible for a medical card which entitles them to free public healthcare including: GP and pharmaceutical services, maintenance and treatment in public wards of hospitals, specialist out-patient services at public clinics, dental, ophthalmic, aural, maternity services and a range of community care and personal social services.

(a) The Health Programmes have been re-organised with the recent organisational reforms into two grants: Primary Community and Continuing Care Services (PCCC) and the National Hospital Office.



Medical cards are issued primarily on the basis of income and cover the individuals and their dependents. However, other criteria, such as age and health status, are also important so that medical card holders are not restricted to the poorest income brackets. Indeed, in 2000, 17% of medical card holders were in the upper two income quartiles (Watson and Williams 2001). Further, from 2001, all people aged 70 years and over are entitled to a medical card (not covering dependents), regardless of income (Government of Ireland 2001).

A new form of medical card was announced in 2005, offering free GP services for low-income non medical card holders finding it difficult to pay for GP visits. Applications are currently being received for these new cards (DoHC 2006a).

Individuals in Category II are eligible for maintenance and treatment in public wards of hospitals subject to nominal charges (€60 per night up to a maximum of €600 in any one year). There is a charge of €60 for attendance at the out-patient and emergency departments (without GP referral note) (DoHC 2006b). This group is also entitled to

	GP	Prescribed Drugs and Medicines	Public Hospital Care		Community Care and Personal Social Services	Others
			Acute Hospital In-Patient	Acute Hospital Out-Patient (Including Emergency Department)		
<b>Category 1</b>	Free	Free	Free Public Care	Free Public Care	Free	Various Entitlement to Dental, Ophthalmic, Aural Care (e.g. Free Treatment for Children in State Schools); Other Benefits.
<b>Category 1 GP Only</b>	Free	Reimbursement Above €85	€60 per night (annual max €600)	Free With GP Referral Note	Various— Depends on Availability and HSE Area	
		Free for Long Term Illness (e.g. Diabetes)		€60 Without Referral		
<b>Category 11</b>	Private GP Charge	Reimbursement Above €85 Per Month	€60 Per Night (Annual Max €600)	Free With GP Referral Note	Various— Depends on Availability and HSE Area	
	Free GP Maternity and Infant Care Services	Free for Long Term Illness (e.g. Diabetes)		€60 Without Referral		

Source: DOHC (2006)

reimbursements of drug payments above €85 per month under the Drug Payment Scheme. Free GP maternity and infant care services and drugs for specified long-term illnesses are also available to Category II individuals. However, this group mainly pay all charges related to GP services.

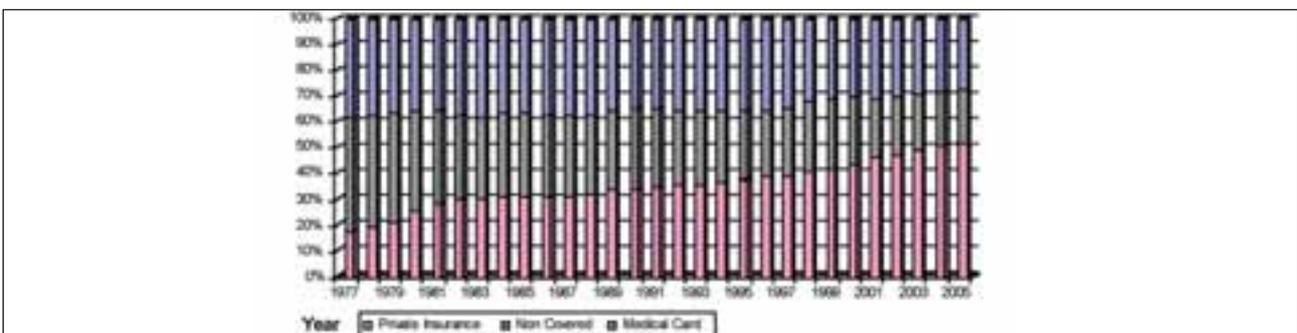
**Coverage Categories**

A large proportion of the population purchases supplementary private health insurance and the majority of these have Category II entitlement (although a small proportion of medical card holders have private supplementary insurance). Category II individuals can be divided into two groups, those with supplementary private health insurance and those without. Thus in practice, the population is made up of three main groups:

- the medical card holders,
- the privately insured,
- the non-insured non medical card holders (labelled as non-covered for ease of reference).

Diagram 2.3 shows how the size of these three main groups has changed from the 1970s to 2005.

**Diagram 2.3: Proportion of Population Health Coverage Status in Ireland 1977-2005**



Sources: (NESF 2002; Wren 2003); (GMS (Payments) Board 1998; GMS (Payments) Board 1999; GMS (Payments) Board 2000; GMS (Payments) Board 2001; GMS (Payments) Board 2002; GMS (Payments) Board 2003; GMS (Payments) Board 2004); Tussing and Wren (2006)

The proportion of the population with supplementary private health insurance has grown from less than 20% in the late 1970s to over 50% now. The expansion of private health insurance has spread to both the medical card and the non-covered groups in the population. The proportion of the population covered by a medical card fell from over 38% in 1977 to less than 30% today. This decline is even greater if we deduct the non-means tested over 70 year old medical card holders. The fall in medical card numbers has been blamed on unfair mechanisms for determining eligibility and it was recognised in the 2001 national health strategy (DoHC 2001) that existing eligibility schemes, including the medical card scheme, “do not adequately reflect the levels at which ‘hardship’ or financial barriers to accessing the necessary care arise” (DoHC 2001: 47). The strategy recommends that the criteria for such eligibility be reviewed to fully reflect the levels at which barriers to accessing care arise.

There are distinctions between these three groups in terms of health status, healthcare utilisation and other characteristics. The average number of annual GP visits for medical card holders is approximately six while that of the privately insured and non-covered groups is less than three (Watson and Williams, 2001; Madden, Nolan et al. 2005). The medical card holders are more likely to be admitted to hospital and to have longer inpatient stays relative to the other groups. These differences reflect in part the lower health status reported for medical card holders, the higher representation of older people in this group, and the lower socio-economic status of this group (Watson and Williams, 2001) (Living in Ireland 2000); (Living in Ireland 2001). The absence of user fees for this group also influences their utilisation of health services. The extent to which this group is over-consuming health services relative to their need for healthcare is not known (Nolan and Nolan, 2004). The socio-economic status of the non-covered group is lower than that of the privately insured, but not as low as the medical card group, and their health status is closer to that of the privately insured than the medical card holders (Watson and Williams, 2001; Living in Ireland Survey Data 2000, 2001). Healthcare utilisation patterns of the non-covered and privately insured are similar with slightly lower levels of utilisation by the non-covered despite the similarity in health status (Living in Ireland Survey Data 2000, 2001).

## **2. Public Private Interface**

### **Public and Private Providers**

Healthcare is provided by a mix of public and private providers in Ireland. There are over 40 public acute hospitals and a small number of private hospitals. Consultants in public hospitals are paid a fixed State salary. These consultants are also permitted to attend to private patients, for whom they receive payment on a fee-for-service basis.

Primary care is delivered by private GPs. The public sector contracts private practitioners to provide GP care to medical card holders, paying them on a capitation basis. GPs are paid on a fee-for-service basis by non medical card holders.

Thus, in both primary and hospital care, public and private care is very often administered by the same staff, using the same facilities. The main difference is the method of payment. Care for private patients is reimbursed on a fee-for-service basis while care for public patients is largely reimbursed on a fixed payment basis.

### **Private Health Insurance: Subsidies and Role**

Private health insurance was introduced in Ireland in the late 1950s with the establishment of the statutory health insurance body, the Voluntary Health Insurance (VHI) Board. The market was opened to competition in the 1990s and BUPA Ireland and VIVAS Health have since entered.

Government policy supports the existence of this market. The national health strategy describes private health insurance as a “strong complement to the publicly funded system” and a vital part of the “overall resourcing of healthcare in this country” (DoHC 2001: 111). This is despite the fact that private health insurance provides only 10% of the overall healthcare resource envelope. In practice, the Government actively supports the market by subsidising the cost of private health insurance. For instance, tax relief (at the standard rate) is allowed on health insurance premia, and is estimated to have cost the exchequer €161.7m in revenue foregone in 2002 (Revenue Commissioners 2004). Such a subsidy was equivalent to 15% of the funding of the private health insurance market in 2004. Furthermore, there are other subsidies to the cost of private health insurance, including the charging of private rooms in public hospitals. The charges do not reflect the full economic cost of such services. In 2002, the private charge per bed day was €307 for the large teaching hospitals compared with an estimated economic cost per bed day of €546 (Commission on Financial Management and Control Systems in the Health Service 2003).

To consider the value of such subsidies, particularly when they benefit richer sections of the population, it is important to review the role and impact of private health insurance in the Irish health system.

### **Community Rating**

The private health insurance market is governed by principles of community rating, open enrolment and lifetime cover (YHEC, 2003). These measures are intended to shape the private health insurance market to be in line with government objectives (YHEC, 2003). Community rating requires that the same premium is charged for a particular product to all individuals, regardless of individual characteristics (e.g. age, gender, health status). Open enrolment ensures that health insurance membership is open to any individual under the age of 65 who applies and lifetime cover obliges the insurance company to renew the insurance contract on an annual basis (provided the individual has not conducted fraud under the insurance contract).

Community rating is described as the “corner-stone of the Irish health insurance system” (DoHC 2001: 33) and is a mechanism to pool the health risk profiles of the health insured population. Revenue saved from low healthcare costs by healthy members is used to pay for the higher healthcare costs by the sicker members. However, the system of



community rating (unintentionally) discourages membership for the non-covered group by imposing artificially high premia on what is a relatively young and healthy population (whose actuarially fair premium would be lower).

### **Cost Containment**

Private health insurance companies have an incentive to control costs. Nevertheless, health services in those countries that rely on private insurance as their main financing mechanism tend to be more expensive than those in countries with tax-based or SHI based systems (McPake, Kumaranayake and Normand, 2002). In Ireland, over 90% of claims are for hospital treatment and insurance companies have made efforts to control costs in public and private hospitals through negotiations with hospital management and consultant staff (Colombo and Tapay, 2004). However, these efforts focus on controlling the price rather than on reducing demand and utilisation continues to rise (Colombo and Tapay, 2004). Private health insurance companies can also use their position to influence the efficiency and effectiveness of healthcare delivery but this is not observed in Ireland (Colombo and Tapay, 2004). Limited coverage of primary care services reduces the incentive for insurers to engage in health promotion and disease management initiatives.

### **Addition or Substitute**

Private health insurance can purchase services that are either additional to or substitutes for what is available in the public health system. Where insurance pays for substitute healthcare, this may free up resources for care of more public patients. However, it may also undermine taxation funding of healthcare in the long run (as those paying privately may be less inclined to pay twice).

Where insurance pays for additional healthcare that would not otherwise have been provided by the public system (e.g. luxury goods of private accommodation; additional consultant care; non-essential procedures etc.), this does not relieve the public system of any burden. If these additional services are provided within the public acute sector, there may be a negative impact on capacity within the public system and may also draw further resources away from public patients. Indeed, it is estimated that half of private hospital care is provided in public hospitals (VHI Healthcare, 2003).

When private health insurance was first introduced in Ireland, its substitution role was clearly outlined. The main purpose was to provide cover for the wealthiest proportion of the population (approx. 15%) who were not entitled to use public services free of charge. Entitlement to treatment in public wards of hospitals was later extended to the whole population and the substitution role of private health insurance has thus become less obvious. Ensuring access to hospital care, good treatment and direct consultant care, and avoiding long waiting times are among the key reasons motivating the demand for private health insurance (Nolan and Wiley, 2000; Watson and Williams, 2001). These indicate that people believe they are buying something additional with private health insurance and not simply a substitute for what is available in the public system.

The preceding discussion has raised questions about the utility of the subsidy to the private insurance sector. There is little evidence of cost containment. The current policy of (crude) community rating may act to exclude unfairly those with no insurance by confronting them with artificially high insurance premia. Further, the additional services covered by the supplementary insurance promote unfair access to services for those who can afford. In the next section the authors explore in more detail the issue of equity, or fairness, within the Irish healthcare system.

## **3. Equity**

This section focuses on distinct sections of the population, exploring the equity of access to services implied by the current funding and policy structures. The purpose of this section is to highlight areas where the principle of equity has not been translated into practice, revealing key weaknesses in the system.

### **Definition of Equity**

While there is often confusion over the precise definition of equity, most definitions relate to fairness of distribution (Mooney, 1983; Donaldson and Gerard, 1993). There are two general approaches to equity which can be applied both to the provision and financing healthcare:

- Horizontal equity, implying the need for the equal treatment of equals
- Vertical equity, implying the unequal but equitable treatment of unequals

The translation of these approaches into working definitions of equity may take several forms relating to the equity of inputs, access, utilisation and outcomes (Mooney, 1983; Whitehead, 1992; Kutzin, 1995). Wagstaff and Van Doorslaer (1993) and Kutzin (1995) argue that equity in healthcare financing relates to payment according to ability and treatment according to need.

Proposals for providing a universal free health service, although considered and debated throughout the political history of the State, have never been fully implemented in Ireland (Barrington, 2000). Nevertheless, in Ireland equity is a central principle in the national health strategy (DoHC, 2001) and there is a commitment to provide access to care for everyone regardless of their ability to pay.

### **Equity in Acute Hospital Care**

Access to hospital care is influenced by the coverage status of the patient. There is frequent reference (e.g. Wren, 2003) to the two-tier structure of public hospital access whereby public patients are subject to long waiting lists while privately insured patients often gain preferential access. Public waiting lists are a well-known problem with public patients waiting extended periods of time before securing a specialist appointment or a date for elective surgery (Wren, 2003). Although waiting lists have been reduced in recent years, there are over 11,000 adults on the public waiting list

for surgical procedures, 24% of whom have been waiting over 12 months. A further 3,806 cases are waiting for medical procedures (NTPF, 2006).

Waiting lists in themselves are not inequitable if those at the top of the list have the greatest medical need. In practice, in Ireland, possession of private health insurance in many cases enables the individual to skip the queue, often to be treated by the same public consultant but in a private capacity. Data for 1999 and 2000 show that utilisation of elective, emergency and day care by private patients increased at a faster rate than public patients (Wiley, 2001). At the same time, public waiting lists persisted (Wren, 2003). This is despite the fact that the general health status of the privately insured population is better than that of the medical card population (Watson and Williams, 2001). Public opinion reveals a belief that private patients receive faster and better access to health services irrespective of medical need (Wiley, 2001). As already noted, attitudinal surveys indicate that ensuring access to hospital care and avoiding long waiting times for public care are key factors driving the demand for private health insurance in Ireland (Nolan and Wiley, 2000; Watson and Williams, 2001).

The concerns about the inequity of two-tier access are not new. The 1989 Commission on Health Funding concluded that such perceptions were accurate and recommended the introduction of a common waiting list for public hospital admission. This would have ensured that cases were taken in order of medical priority rather than public/private status (Nolan and Wiley, 2000). Instead, the bed designation system (restricting the proportion of beds allocated to private patients) was introduced to safeguard the access of public patients to hospital beds. However, data for 1999 and 2000 found higher than expected proportions of private patients in in-patient beds relative to the designated proportions of public and private/semi-private beds (Wiley, 2001).

There is also concern that the quality of treatment received by private patients is better than that provided to public patients with the latter more likely to receive consultant-led rather than consultant-provided care (Wren, 2003). Other incentives cited for purchasing private insurance include ensuring good treatment and direct consultant care (Nolan and Wiley, 2000).

### **Equity in Primary Care**

Access to primary care is uneven across the population. Non medical card holders are required to pay out-of-pocket for GP care on a fee-for-service basis. Private health insurance in Ireland has mainly covered hospital care although products providing out-patient coverage are now increasingly being offered (OECD, 2004). There is some evidence that access to GP care for low income, non-medical cardholders is restricted because of affordability problems. The introduction of the new GP-only medical card is intended to address this concern. Wren (2003) estimated that a visit to a GP costs approx. one-third of the weekly income of an individual earning just above the medical card income threshold.

On the supply side, the incentive structures facing GPs in Ireland could give rise to differential patterns of referral across patients. GPs are paid an annual capitation fee from the government for attending to medical card patients while they are paid on a fee-for-service basis for consulting their private non medical card patients. Theory predicts that GPs have an incentive to favour the treatment of private patients although this has not been researched in the Irish context (Tussing and Wren, 2006).

On the consumer side, medical card holders may over-consume (free) GP services while low income, non medical card holders may be under-consuming GP care. It has long been known that user fees deter both appropriate and inappropriate use of services, and are therefore a blunt instrument for reducing inappropriate use (Beck and Horne, 1980). It is possible that this feeds into inappropriate utilisation of hospital care with the latter patients self-referring to emergency departments without first consulting their GP. The statutory charge for non-referred attendance at the emergency department is intended to restrict such usage. However, self-referral to an emergency department might still be logical as it ensures prompt medical attention at the highest end of the treatment scale and cuts out the risk of having to pay for more than one GP visit. Such patients might also be induced to delay their request for healthcare (in the hope that treatment costs can be avoided) giving rise to more complicated and costly treatment cases.

### **Key Weaknesses**

#### **Perverse Incentives**

The two-tier system of acute hospital care and its associated inequity is supported by a range of financial incentives. Much privately insured care takes place within the public hospital system and there is little incentive to change this. As noted above, private and semi-private care within public hospitals is subsidised by the government health budget. The extent of this public subsidy is estimated to be close to 50% (Commission on Financial Management and Control Systems in the Health Service 2003).

Consultants and hospital managers also have strong financial incentives to maximise the number of private patients accommodated within the public hospital system. Consultants in public hospitals are allowed to receive fees for treating private patients in addition to their fixed State salary. The bed charges for private beds received by the public hospitals are higher than the standard charges for public beds. The fully insured individual is financially unaffected by the location of care and has no incentive to alter the current state of access to public hospitals.

The inseparability of the public and private acute hospital system contributes to the persistence of two-tier access. The private system cannot cater for all private patients. Some procedures (e.g. treatment of complicated cancers etc.) are only available within the public system.



Financial incentives also affect inequity in primary care. GPs may prefer to locate themselves in areas where the catchment population is non medical card, relatively wealthy so that they can charge a higher proportion of their patient list on a fee-for-service basis. Analysis has found that in areas of Dublin with low concentrations of medical card and low paid patients, there are three times more GPs than in less wealthy areas (Wren, 2003).

As noted earlier, treatment and referral decisions may be influenced by the coverage status of the patient (Tussing and Wren, 2006).

### **Lack of Transparency**

Ultimately, there is a lack of transparency in the health financing system in Ireland. Nominally, the whole population contributes via taxation to the public health system. This provides funding for primary (and other) care for the medical card population and entitles the whole population to public hospital care (although non medical card holders are subject to nominal charges). A large proportion of the population also pays for private health insurance to secure preferential access to the public hospital system and to receive additional services including consultant-provided care and private/semi-private accommodation. The picture is complicated by the public subsidisation of both the cost of private health insurance and the cost of private care within public hospitals. There is further complication with the measures taken to address the problem of public waiting lists. The National Treatment Purchase Fund (NTPF) purchases treatment for public patients on waiting lists in private facilities (in Ireland and abroad). The State is effectively paying twice to provide care to some of its public patients. The range of financial incentives and flows of subsidisation in the system suggest uneven access of care for the medical card, the privately insured, and the non-covered groups in the population.

### **Summary**

The Irish healthcare system is difficult to classify. It is unique in the former EU 15 countries in having no subsidy for access to GP services for the majority of the population, and is unusual in the high proportion of the population that has supplementary private medical insurance. Most of the funding of healthcare comes from Government, but there are important effects on access to care resulting from the relatively small amounts of funds coming from private insurance and user charges.

Perhaps the most serious shortcoming of the current complex set of financing arrangements is that the overall financing burden is not well understood. Recent work (Smith, 2006) updating previous research on equity in financing in Ireland illustrates the problem. Careful analysis of each of the financing mechanisms shows a wide range of (mainly unplanned and unintended) inequities. Those on very low incomes are winners, but those on fairly low incomes face full or near full cost charges for primary care. Those with private medical insurance are subsidised by tax relief on premia and less than full cost charges for private care in public hospitals. The system of 'community rating' in the private medical insurance has inter alia the perverse effect of transferring funds from any young low income members to those who are on average richer, thereby being a serious disincentive to join for young, generally healthy people with low incomes.

It is then appropriate to ask what a health insurance system can do to address some of these weaknesses. Certainly, having earmarked funds for the health sector allows real transparency in financing. The advantage of this is that it allows open debate on the value of different subsidies and funding flows. SHI systems are often a more acceptable funding mechanism for citizens and this may allow extra revenue to be raised with which some of the supply bottlenecks can be alleviated. Equity and efficiency can also be further improved by appropriate design of SHI, but the precise effects depend upon the SHI option chosen and the specification of benefits and financing. Such issues are explored in the following chapters to see what SHI options might be useful in an Irish context.





## Chapter 3: Options for SHI

### 1. Introduction

The aim of this chapter is to explore the different SHI design options that would best meet policy objectives in the Irish context. Chapter 1 demonstrated the wide range of possible designs for SHI. In part, these different designs reflect the variety of contexts within which SHI has been implemented in Western Europe. However, they also reveal diverse policy objectives. To determine the right model or version of SHI for Ireland it is vital to consider the most important objectives for the Irish health system, such as equity and efficiency. SHI is a mechanism to achieve a policy and not a policy in itself. Policy priorities should determine the design of SHI. Consequently, this chapter draws on the review of health financing and provision set out in Chapter 2. Any SHI system must help address the system weaknesses, highlighted by that analysis, while building on the strengths of current health financing and provision mechanisms.

The authors review how SHI might best serve identified goals by reviewing the design options in the Irish context. This allows a select number of scenarios to be developed in Chapter 4. The resource requirements for these scenarios are then calculated and their feasibility explored. It is important to note that the resource requirements of any SHI system include both the implied cost of running the new policy and the cost of transition from the current arrangements. The latter is often ignored. The transition costs may be quite substantial especially if they require a restructuring of the system. In later chapters, the authors take care to highlight health system bottlenecks to expanded service delivery and the activities that will be needed to alleviate these constraints.

### 2. Recap of Policy Review and Objectives

Chapter 2 highlighted the key features of the Irish health system in terms of its financing and expenditure. Salient features include the large increase in public funding to meet new demands and repair the underinvestment of previous decades. Despite this, the influence of the private sector is notable, even though private funding does not contribute a substantial proportion of overall funding. The primary healthcare system is essentially private, with government subsidy to certain population segments. Evidence shows that the coverage of the population by the medical card system declined by 7% from 35% of the population in 1996 to 28% in 2005 and is less devoted to protecting those on low incomes, see Chapter 2. The hospital system is plagued by limited capacity and for many services long waiting lists or waiting times. Public concern about limited access to required services has led to large growth in the supplementary private insurance system, which now includes over 50% of the population. Interestingly, there is a substantial subsidy by the state to this private sector activity. Indeed, public subsidies are encouraging the purchase of supplementary private insurance and as such are ensuring preferential access to services and, consequently, inequity in the health system.

Yet the current Irish Government has a policy commitment that:

“Access to healthcare should be fair. The system must respond to people’s needs rather than have access dependent on geographic access or ability to pay.” (DoHC 2001: 18) (authors’ italics)

Indeed, the stark inequities in the current system are recognised by Government. The Department of Health and Children reaffirmed in a recent policy document the need to address health inequalities in more radical ways than in the past. Equity and fairness are included as the first principle of health system development and central to developing policies (p17, 18 *ibid*) in the national healthcare strategy (Quality and Fairness: A Health System for You).

A second thread of Government policy relates to efficiency or value for money. There are generally two important elements of efficiency, allocative and technical. Allocative efficiency focuses on which activity to pursue. Technical efficiency is concerned with getting the right mix of inputs into a specific activity (Brown and Jackson, 1987; Smithson, 1996). Providing a people centred service (DoHC 2001: 104) requires focusing on the needs of patients (allocative efficiency), while reducing waiting times for public patients (DoHC 2001: 101) which requires reorganisation of services (technical efficiency).

Subsequent sections will focus on how the design of SHI might help improve equity and efficiency.

### 3. Key Choices

#### Population Coverage

In many countries full protection of the whole population is often only achieved as a long-term objective of an SHI system. All countries with social health insurance started by protecting subgroups of the population, such as employees in large enterprises (Normand and Weber, 1994). Nevertheless, the problem with covering sub-groups is that frequently the “easiest” groups get covered first, which usually includes those that are better off and in formal salaried employment. These groups tend to be those that need the least help from government to access healthcare.

Further, an incremental approach faces two obstacles to extending protection to more of the population (Normand and Weber, 1994; Thomas and Gilson, 2004):

- technical problems with incorporating higher risk groups
- administrative difficulties with extending coverage to those outside formal salaried employment
- political opposition from existing better-off groups already in the insurance scheme to having to extend the insurance coverage and subsidise the healthcare of the poor.

Each of these sets of constraints is reviewed below.

### **Technical**

Insurance only works if some people pay more in contributions than they take out in services. Hence “the lucky” will inevitably protect “the unlucky”. In social health insurance, in addition, those who can afford to pay more subsidise those with more limited resources. Where equity is an important goal, this cross-subsidy is necessary if people are to receive treatment according to need without being constrained by their ability to pay. Indeed, to allow for sufficient financial resources to offer protection to a group, there needs to be a mix of good and bad risks. Good risk groups tend to be the young and employed without dependents. Higher risks tend to be the elderly and unemployed or those in dangerous jobs. Typically private insurance schemes will differentiate on the basis of risk, charging higher premia to those with higher risk and excluding, in part or completely, those with very high risk who must fall back on publicly provided services.

However, social health insurance does not charge risk-related premia and will not exclude anyone from an eligible group (as discussed in Chapter 1). Instead, an SHI system needs to ensure that it captures population groups with both good and bad risks to achieve financial balance. To provide SHI coverage to certain priority groups it may be necessary for the government to provide deemed or credited contributions on their behalf. This can be done for those who cannot pay (such as the unemployed) or should not pay according to existing entitlements (e.g. over 70s).

### **Administrative**

Salaries and wages from formal sector employment are declining as a proportion of total incomes in many countries as unemployment (including ‘early retirement’) rises, contract staff increase, fewer peoples are employees of large firms and there is a growth in self-employment. Yet there are administrative difficulties in extending coverage of insurance beyond those in the salaried formal sector, however desirable. Typically there may be problems with registering those who are agricultural workers, the casually or self-employed and certain vulnerable groups such as the unemployed or disabled. Problems assessing the income of those who are self-employed relate to that fact that:

- Incomes may be variable;
- Personal and business income can be confused;
- There may be incentives for people to understate their income.

It may be important to use other existing systems to identify the required payment or subsidy from these groups. The assessment for income tax can be used to gauge other types of liability, including insurance. Flexibility of payment for SHI may also be important, so that disbursements can be made on a one-off basis, where appropriate. Further, the weight of having to pay health insurance contributions as both an employee and employer may be too much for someone who is self-employed and it may be that SHI is offered at a reduced rate to encourage compliance and avoid burdening this group.

### **Political**

The history of financing reform is littered with examples of opposition to proposed changes (Swenson and Greer 2002, Oliver and Dowell 1994, Harrison and Calltorp, 2000, amongst others). Typically it is those financing reforms aimed at improving equity (by extending or improving access and/or by increasing subsidies to the poor) which face the most intense opposition, typically from the urban and wealthy who stand to lose from reform (Thomas and Gilson, 2004). The latter groups tend to be better at mobilising political support and blocking reform processes. Such issues are further explored in Chapter 6.

### **In the Irish Context**

Given the importance of fairness in the Irish healthcare system and the prevalence of private health insurance, it is important that SHI addresses some of the current imbalances in equity of financing and access. It is clear from Chapter 2 that there is a section of the working population that neither benefits from the medical card scheme nor is willing and able to afford supplementary private health insurance. While this group is an economic asset to the country it does not have access to a fair share of health benefits. Further, the poorer population, even if they qualify for medical cards, do not get special access to hospital healthcare. Once these groups are covered then there would appear to be in effect extra insurance coverage for all sections of the population which may start to approach conditions of horizontal equity. Once all sections of the population are covered this raises the possibility that this segmented insurance market could be harmonised into one system. This might make it easier to address, on a system-wide basis, issues of efficiency and equity.

### **Compulsory vs Voluntary**

An important consideration in the introduction of any SHI scheme is whether to force people to take the insurance or make it a matter of choice. While it may be politically more attractive to make it a matter of choice, this can undermine an SHI system. The risk is that people will choose private insurance as long as their premia are lower than those for social health insurance. As soon as their premia rise, such people will switch to social health insurance. In other words while people are good risks they will seek the lower premia available from private insurance or just pay their own way. Typically, this is when they are young and do not have dependents. When they get older and become bad risks then it will benefit them to let others subsidise them. Hence a voluntary system can lead to only bad risks joining (or adverse selection) and this can undermine the whole SHI programme, as discussed earlier. A mandatory system avoids this risk and allows more extensive cross-subsidy. Indeed, compulsory membership in SHI schemes, even for the young and healthy, can be justified if it is seen as a “contract between generations”. At some stage in life, people expect to



become a bad risk. Therefore single people who pay more now are actually investing in their future care as they will receive subsidies for their healthcare later in life.

Some countries have tried to develop a voluntary system while negating issues of adverse selection and fraud. Useful strategies include the following, though none of these steps entirely resolves the problems:

- Qualifying conditions for membership: e.g. pensioners can only participate if they have been members for 50% of their working life
- Waiting periods: voluntary members must have a waiting period before they can claim
- Limited voluntary access: each person has the chance to join only once in his or her life.

### **In the Irish Context**

There is already substantial experience with voluntary supplementary private health insurance in Ireland. However, membership is clearly linked to economic means leaving those least able to afford without supplementary hospital cover. While mandatory membership is better for the management of risk it is not always acceptable. There are several options that could be pursued. First, it might be mandatory for each individual to be covered by some form of health insurance, whether private/voluntary or social. Further, there might be some balancing of risk between the private and social schemes through transfers. Payment for the social health insurance scheme might be paid entirely by the State or organised on the basis of an assessment of means. This would allow those currently without hospital cover to be on an equal footing with those who currently have supplementary private insurance. Another option might be to make a social health scheme mandatory for all the population except for those in certain target employment groups. Here, however, the State might offer subsidies to encourage membership in these groups.

### **Benefits and the level of care**

Given that resources are always constrained it is important to review whether SHI can fund all services for its members at any particular level or whether there will only be partial, or even no, funding of a particular service and drug. For instance costly services which require expensive imported drugs or equipment may be excluded from a benefit package if not deemed a priority. In such cases the patient has to purchase the service or drug privately. In other cases the patient may face a charge, though not at full cost, called a co-payment. The aim of the co-payment is to discourage misuse of the costly service. A typical problem with insurance is that patients will be tempted to get their value for money once they have purchased membership and may use services that they do not strictly need. This is called moral hazard. The co-payment is one device which acts to limit moral hazard by forcing patients to pay in part. Alternatively patients may pay up-front and then get reimbursed for their expenditure. The problem with these patient payment mechanisms is that they can impact on the poor and stop them getting important services. Other ways of limiting or rationing care to make a scheme affordable may involve determining an agreed list of drugs or services which will be covered by insurance and/or covering only a limited number of visits at a specific level.

It is important to design the benefit package to suit the needs of Ireland. Policy makers must choose what the priorities for an SHI system are and what can be excluded from this type of support. Along with this prioritisation there must be an understanding of costs of the treatments and likely utilisation to work out the financial affordability of any package. Indeed, policy makers must engage in an iterative process of prioritisation of health sector needs and calculations concerning the cost of service delivery and actual (and future potential) use of services.

A related issue in the discussion of what is in the SHI benefit package is to consider what levels of care will be covered by insurance. Almost all health insurance schemes cover hospital benefits. However, there is more variation on the issue of whether Primary Healthcare should be included. Where patients in a country are already used to paying for primary care, the inclusion of such services within PHC is much more likely to be acceptable. Given the current private nature of PHC it would be interesting to calculate the extra costs that would be incurred by including PHC in an insurance package, especially for those without supplementary private health insurance or medical cards. The extra costs incurred by covering target groups would actually save costs and reduce congestion at the hospital level.

Other issues about types of care to be covered include a discussion of social care, mental health, optical services and dentistry. Typically these are not included in an SHI scheme, or only partially included, but they are an important priority for Ireland (DoHC, 2001) and so should be considered carefully as options for the design of SHI.

### **In the Irish Context**

It is interesting to explore the conditions surrounding the packages of supplementary private insurance to see what light these might throw on a possible SHI package of benefits. These packages typically offer some form of private or semi-private care, within public and private hospitals. They guarantee access to consultants. These packages typically cover general hospital in-patient care with some caps or financial limits for specific diseases or conditions, such as cancer or at specific high-cost private facilities. They also have "waiting periods" before members can claim reimbursements: a general waiting time after enrolment in the scheme and a longer one for some pre-existing high-cost conditions. Some packages also make a contribution toward PHC costs though this is generally insufficient to cover the entire cost of visiting a GP. Co-payments are also used either directly or indirectly (non-refundable expenditures) for some services. (Source: [www.vhi.ie/info/products](http://www.vhi.ie/info/products) accessed 28/04/2006; BUPA, 2006).

Social care has become an increasingly important policy issue. Currently, some supplementary private packages afford some assistance in this area in terms of home nursing, convalescent care and psychiatric in-patient care, though the

amount is often limited either by amount or days covered per year and is typically insufficient to cover all direct costs associated with the care. While the packages generally offer some assistance with dentistry and optical services, the conditions for use are often limited or costs are not fully covered.

It would appear that it would be useful to model options for SHI which:

- include/exclude comprehensive Primary Healthcare cover.
- offer a minimal/comprehensive level of cover for social care services, dentistry and so on.

### **Provider Payment Mechanisms**

SHI is a framework for collecting and managing funds to support access to care. It is normal for the provision of care to be by a range of public, voluntary and private providers, and a critical issue is the way in which payments to providers are made. An appropriate mix of payment mechanisms takes into account the resulting incentives to patients and care providers, and puts in place incentives for the delivery of efficient and equitable service delivery. The evidence shows clearly that patients are only partially informed about the usefulness and effectiveness of certain treatments, and that providers, however professional, do respond to incentives. The recent experience of countries that have introduced SHI funding is that they did not pay sufficient attention to the incentives generated to patients and providers, and this led in some cases to serious cost increases and inefficient use of healthcare resources (Normand and Weber 1994). Nevertheless, provider payment systems must allow the providers to achieve a reasonable income in order to motivate them to produce services of good quality. There will be winners and losers in any change to SHI. Resistance from key stakeholders who have done well from previous systems can undermine reform if not handled carefully. This issue will be further addressed in Chapter 6.

There are many different methods for paying providers, with different resulting incentives. Their performance can be measured against a number of criteria including: the quality of healthcare services; cost containment; and the complexity and costs of administration. Below the authors offer a brief description of each payment mechanism along with an evaluation of its strengths and weaknesses (see also Table 4.1):

#### **Fee-for-service**

Providers are paid for each treatment, act, or product they provide. Typically providers are paid according to a fee schedule, where prices displayed are either compulsory or a recommended guide or an upper-boundary. Typically, a fee schedule is negotiated between the major stakeholders. Fee for service encourages the production of services, potentially beyond what is strictly necessary, and thus inflates the cost of healthcare. Nevertheless, this may also lead to better quality care as providers have an incentive to give services. The precise design of the fee schedule can impact on performance considerably. The administrative costs of this system are very high because of the complexity of billing procedures and monitoring.

#### **Case Payment**

The case payment system is based on a single case rather than a single act. In many cases the fee paid depends on diagnosis, using a case-mix system such as “diagnosis-related groups” (DRG). DRGs have an associated fee paid to the provider. DRG systems have better cost containment than fee-for-service payment, and usually have lower administration costs, but can lead to inappropriate cost cutting. .

#### **Daily Charge**

These charges are used in relation to hospital stays. They cover all expenses associated with a patient. The fees are based on total costs divided by the number of patient days incurred in the same period. The fee is relatively easy to establish and administer, but may encourage hospitals to keep patients in longer than necessary.

#### **Bonus Payment**

Bonuses are paid to providers as an incentive to achieve certain objectives in terms of system performance, such as lowering the consumption of drugs. The precise bonus will vary according to the objective. The costs of monitoring and administering the system must be lower than the costs of setting up the bonus system in the first place.

#### **Capitation Fee**

A capitation fee covers services for one health fund member over a certain period, normally a year. The fee is paid to a nominated provider who then has the responsibility to provide healthcare for that member. The insured person can choose which provider to go with and this, along with the right to change, helps encourage competition and high quality service. In most systems the fees vary according to age, gender and may also vary by area of residence. The effects of the capitation payment on cost control are excellent but given the guaranteed payment of the provider there may not be much incentive to provide high quality care. However, if patients can switch providers, assuming there are enough alternative providers, then this may improve the incentive for the provider to offer a quality service.

#### **Budget**

This is the payment of a particular sum that covers the total costs of services or products delivered during a given period of time. An input-oriented budget is based on previous cost experience. This incremental approach is typically quite inefficient, inequitable and resistant to policy change. The budget system has in some countries been reasonably effective at controlling costs though there is always the danger that necessary services are not provided to make sure the provider is within budget. Administration for the health fund tends to be relatively easy.

**Table 3.1: Comparison of Different Payment Systems and their Performance**

Payment System	Definition/Basis for Payment	Cost Containment	Quality	Administration
Fee-for-service	Single act or product	Very poor	Very good	Very difficult
Case Payment	Single case diagnosis	Good	Fair	Difficult
Daily Charge	Patient day	Fair	Poor	Very easy
Bonus Payment	For specific acts or behaviour	Good	Good	Easy
Capitation Fee	All services for one person in one period (a year)	Very good	Fair	Very easy
Budget	All services for health fund members in one period	Very good Very good	Fair	Easy

Source: Normand and Weber (1994), Derived from Tables 14 and 15, p77.

It is to be expected that, in line with international experience, a combination of these provider payment methods will be used in an SHI system for Ireland, tailored to suit different policy priorities.

#### **In the Irish Context**

Key current payment mechanisms in the Irish context include:

- The use of budgets to cover most hospital costs;
- The use of DRGs or case payment for reimbursement of part of the cost of hospital services;
- The effective use of capitation fees by the government to reimburse GPs for medical card recipients of primary care;
- Fee for service for most payments by the supplementary medical insurance services and for most primary care users.

#### **Organisational Structures**

##### **Funds**

It is possible to have more than one health insurance fund to buy services and reimburse patients. More than one fund may, through competition, lead to better management and service delivery. There is little evidence from international experience to support the view that competition between funds means lower costs and improved efficiency. Instead, with several health funds there is a danger that the price of services will be inflated since the power of being a single purchaser (monopsony) is lost. Funds may also refuse to take on high-risk subscribers. A number of checks and balances are therefore needed if more than one health fund is in place:

- The contracts with all providers should be the same for all funds
- There should be no substantial difference in benefit packages
- The risk structures for different funds should be equalised
- All funds cannot refuse to admit anyone who qualifies for coverage

Without these provisions there is a serious risk of cost explosion and inadequate pooling of risks.

##### **Provision**

Competition between providers may be useful for reducing costs and improving the quality of care. Nevertheless, it can also lead to the loss of economies of scale and to duplication of services and the waste of resources. In addition it is sometimes not possible to have competition though the presence of the potential for competition might provide benefits. Where organisations compete periodically for the management of facilities this may possibly serve the same purpose as competition of provision in terms of quality performance. Nevertheless, there is an absence of good data in the international literature to make any conclusive claim on the effects of real, or potential, competition.

While organisational structures are vitally important, it is not clear that any one type of design, whether related to funding or provision, is necessarily more efficient than any other. Much may depend on the design details and regulatory environment. Hence for developing the SHI options and building the scenarios for costing, different organisational structures are excluded. Nevertheless, they will be considered in evaluating the feasibility of different approaches in Chapter 6.





## Chapter 4: The Scenarios for SHI and their Costs

### 1. Structure of healthcare financing under SHI

As emphasised throughout the report, SHI is a mechanism and not a policy in itself. One reason for the inequities and inefficiencies in the current Irish health system is the complexity of the financing arrangements and the consequential lack of transparency in financial flows, (see Chapter 2). This makes it more difficult to plan and monitor the distribution of the burden of paying for health services, and makes it likely that the pattern of this burden will be irrational. The introduction of SHI is an opportunity to change this and to have a simpler system where it is clear and transparent who is paying how much and what their entitlements to care are. It should be remembered that in healthcare finance all money comes from citizens. There is therefore no advantage to citizens of State subsidies over SHI since the latter also comes from taxation of citizens. It is in principle quite possible for all health-related equity objectives to be met through the sensible design of SHI. Any system of healthcare finance that has miscellaneous and opaque subsidies risks unplanned distribution of the burden of who pays for what.

For simplicity the assumption is made that, under SHI, contributions will be paid on taxable income as a proxy for ability to pay. Although some countries do have a cap on SHI contributions it is assumed that for Ireland, as in the case of income tax, there would be no cap. Those currently below the threshold for paying income tax would be charged a zero fee for SHI membership, and those above this level would pay only on income above the tax free allowances. This would make the SHI system mildly progressive since those on higher incomes would pay a higher proportion of incomes on SHI. It should be noted that, in introducing SHI, government would have to review the overall burden of taxes and charges to ensure that wider equity and incentive policies are met.

One reason for subsidies to SHI in many countries is the perceived over-reliance on earned income as the 'tax' base for SHI. As pointed out above, it is possible to supplement payroll charges with other funds such as taxes on health damaging goods that are paid directly into the SHI fund(s). However, it is also possible to get round this problem of perceived over-reliance by reducing general taxation on incomes. In the scenarios outlined below this has been the approach. The models do not have any subsidies from general taxation, but insofar as SHI finance replaces general taxation finance it is assumed that this will lead to a reduction in direct tax on incomes of the equivalent amount.

The models of SHI proposed in these scenarios are therefore pure in the sense that they aim to maximise the advantages of SHI in terms of acceptability and transparency, and would ultimately involve 100% of healthcare finance going through the SHI system. This includes capital costs. A sustainable system requires funds for repair, refurbishment and replacement of capital. This is part of the cost of running the system and can be built into the funds paid by SHI for services.

Conversely some key costs of an effective health system have not been included in the scenarios below. The two most important are the costs of providing basic training for healthcare professionals and the costs of supporting health and biomedical research.

### 2. Scenarios for costing

Drawing on the discussions in Chapter 3, this section presents four options for SHI design in Ireland. These options can be considered as alternatives or stages in a developmental process. It is assumed in all SHI models that they will be entirely self-financing (i.e. that the costs of maintenance of the system, once up and running, will be met by the contributions of members). The full costs of running the system relate to the costs for paying all capital and recurrent cost items, including the costs of replacing and maintaining infrastructure and equipment. Each scenario will be financed solely through member contributions and these will be fixed at a constant proportion of salaries or wages above the tax free allowances. For those without salaries/wages, the premia will be set at zero, as noted above.

There will initially need to be Government investment in the preferred scenario to establish it, in terms of expanding current system capacity and putting in place all the necessary administrative and service structures. This investment will be phased over several years. Such transitional costs are not included in the estimates described in this chapter and will be reviewed in subsequent chapters.

#### I) Levelling up access and quality of all services (The 'Rolls Royce' Option)

This version of SHI involves upgrading the access to healthcare services for the worst-off segments of the population to that of the best-off. Hence it ensures provision of all hospital services currently available in the public and private sectors through supplementary insurance to the entire population, including guaranteed and timely access to hospital consultants. In addition, members will receive free primary healthcare (PHC) consultations, free PHC prescriptions and some limited support for long-term care.

#### II) The Priority to Primary Care Model

This involves the provision of the same package offered for PHC as in the Rolls Royce Model, with free PHC consultations and prescriptions. It also involves some minimal hospital support through the removal of fees to be paid for inpatient stays for the uninsured and the removal of charges for all for using Accident and Emergency and OPD services .

#### III) The Priority to Hospital Services Model

As in the Rolls Royce version, members are entitled to a comprehensive package of hospital benefits, including semi-

private and private rooms and quick access to consultants. There is also some support to PHC attendance. It is proposed that all PHC visits for those currently not on medical cards are charged at a fixed price of €20, with SHI providing a capitation fee to compensate GPs. £20 per visit still represents a potential barrier to use of GP services but would reduce the cost to patients by around 50% compared with current prices.

**IV) Making only small improvements in access ('The Mini')**

This involves the removal of all fees for hospital attendance and fixed price charges for PHC. All inpatient (IP), and OPD charges are removed, as with II, and all A&E attendances and PHC visits for those currently not on medical cards are charged at a fixed price of €20. Further, the provider payment system is shifted towards a DRG or capitation based system and the savings incurred, once the new system is running well, will be invested in expanding public sector services to alleviate current bottlenecks.

**3. Costing the Options**

**Methods**

The data to populate the models are drawn from existing secondary sources including government and the private insurance sector. They relate to historical costs and utilisation by different population groups. Consequently, the estimates are subject to existing data limitations and to potential behavioural change that will result given the new financing structures and inherent incentives. The cost projections and data sources are shown in Tables 4.1 and 4.2.

The summary costs for each option, presented later in this chapter, are indicative, providing approximate price tags for different SHI mechanisms. They represent the cost of running the new SHI system once established. As noted earlier, they do not include the one-off investment costs of establishing any SHI option. This is reviewed further in Chapter 6. The additional information requirements, to calculate the one-off capital costs for expanding hospital capacity and to refine the current estimates of the associated recurrent costs, are noted in the annex to this report.

**Table 4.1: Estimating Incremental Costs – Scenarios, Assumptions, Projections and Data Sources**

I. Upgrading access to hospital care (Roths Royce, Priority to Hospital Services)	Cost <sup>1</sup> and utilisation data	Data sources	Non-insured population (millions)	Per capita cost of upgrading hospital care <sup>2,3</sup> €		Total additional costs €m	
				High <sup>4</sup>	Low <sup>5</sup>	High	Low
Benefits of privately insured hospital care include: private/semi-private accommodation (i.e. more 'hotel' facilities); reduction in waiting times; consultant-provided care. To proxy these benefits, the authors apply supplementary charges for privately insured hospital care, adjusting for estimated utilisation rates for non-insured population, and include measures to improve access to consultants.	Per bed/day charges for private and semi-private care in public hospitals	DOHC (2006)	2.01	692.80	555.37	1,392	1,116
	Cost estimate of introducing consultant-provided care	National Task Force on Medical Staffing (2003)					
	Supplementary private health insurance costs	DOHC Health Statistics					
	Average in-patient utilisation rates for non-insured population	Living in Ireland Survey (2001)					

<sup>1</sup>All costs are in 2004 prices.

<sup>2</sup>Costs of daycase and out-patient services are not upgraded.

<sup>3</sup>Assume current in-patient utilisation rates of non-covered population reflects unmet need apply insured population utilisation rates to adjust for unmet need.

<sup>4</sup>Private bed charges.

<sup>5</sup>Semi-Private bed charges.



2. Extending access to free primary health care (Rolls Royce, Priority to Primary Care)	Cost <sup>1</sup> and utilisation data	Data sources	Non medical card population (millions)	Per capita cost of extending free primary care €	Total additional costs <sup>2</sup> €m
Application of costs of GP and prescription services under the GMS scheme, adjusting for estimated age and GP utilisation profiles of non medical card population.	GP capitation charges (by age group)	Primary Care Reimbursement Service (formerly the GMS (Payments) Board) Annual Report (2004)	2.89	311.92	903
	Per capita prescription charges for medical card holders (by age group)	Primary Care Reimbursement Service (formerly the GMS (Payments) Board) Annual Report (2004)			
	Average GP utilisation rates by medical card/non medical card groups	Living in Ireland Survey (2001)			

<sup>1</sup>All costs are in 2004 prices.

<sup>2</sup>Costs of Drug Payment and Long-Term Illness refund schemes deducted from total primary healthcare costs.

3. Removal of in-patient and out-patient charges (Priority to Primary Care, Mini)	Cost <sup>1</sup> and utilisation data	Data sources	Non-covered population (millions)	Per capita cost of removing in-patient cost-sharing <sup>2</sup> €	Total additional in-patient costs €m	Non medical card population	Per capita cost of removing OPD charges €	Total additional OPD costs €m
Application of public in-patient and out-patient charges to utilisation.	Public charges for hospital care (in-patient, out-patient)	DOHC (2006)	0.98	48.60	47.67	2.89	29.68	85.91
	Average in-patient utilisation rates by coverage category	Living in Ireland Survey (2001)						

<sup>c</sup>All costs are in 2004 prices

<sup>2</sup>Assume current in-patient utilisation rates of non-covered population reflects unmet need apply insured population utilisation rates to adjust for unmet need.

4. Removal/reduction of A&E charges (Priority to Primary Care, Mini)	Cost <sup>1</sup> and utilisation data	Data sources	Non medical card population	Per capita cost of removing A&E charges €	Total additional A&E costs in Priority to Primary Care Model €m	Non medical card population	Per capita cost of reducing A&E charges (Mini) €	Total additional A&E costs in Mini €m
Application of A&E charges to utilisation.	Public charges for A&E care	DOHC (2006)	2.89	16.16	46.78	2.89	10.77	31.18

<sup>1</sup>All costs are in 2004 prices.

5. Support for GP attendance (Priority to Hospital Services, Mini)	Cost <sup>1</sup> and utilisation data	Data sources	Non medical card population (millions)	Per capita cost of allowance €	Total additional costs €m
Costs of support per GP visit applied to estimated GP visit rates of non medical card population.	€25 per GP visit		2.89	60.00	173.69
	Average GP utilisation rates by coverage category	Living in Ireland Survey (2001)			

<sup>1</sup>All costs are in 2004 prices.

**Table 4.2 Costs of Existing Services**

Item	Data sources	Notes
Hospital costs <sup>1</sup>	Revised Estimates for Public Services 2005 (Provisional Outturn for 2004)	Adjustments made for Education costs. Funds from National Treatment Purchase Fund deducted in Rolls Royce and Priority to Hospital Services.
Medical card costs	Primary Care Reimbursement Service (PCRS) (formerly GMS (Payments) Board)	
Other primary health care costs	Revised Estimates for Public Services 2004, PCRS	

<sup>1</sup>All costs are in 2004 prices.

### Costs

The summary costs of the four models are presented in Table 4.1 and Diagram 4.1 which highlight the costs of the options by key component. Included in the costing of the Rolls Royce and Priority Hospital models are high and low estimates for the extension of “supplementary” hospital access to cover the entire population. Diagram 4.2 supplements this with a breakdown of costs into existing and additional expenditure. The latter allows a better analysis of the extra funds required. In all cases the additional costs required to finance different models are far less than the total costs of running the Irish health system.

As has been noted, the implementation of SHI is not seen simply as being an add-on to the current mechanisms of financing. Items which are currently financed through the taxation system will in all models be provided through the SHI system. In all models, SHI will be the largest single source of healthcare financing in Ireland, over user charges and private insurance.

**Table 4.1: Summary of the SHI Model costs (Euro million, 2004 prices)**

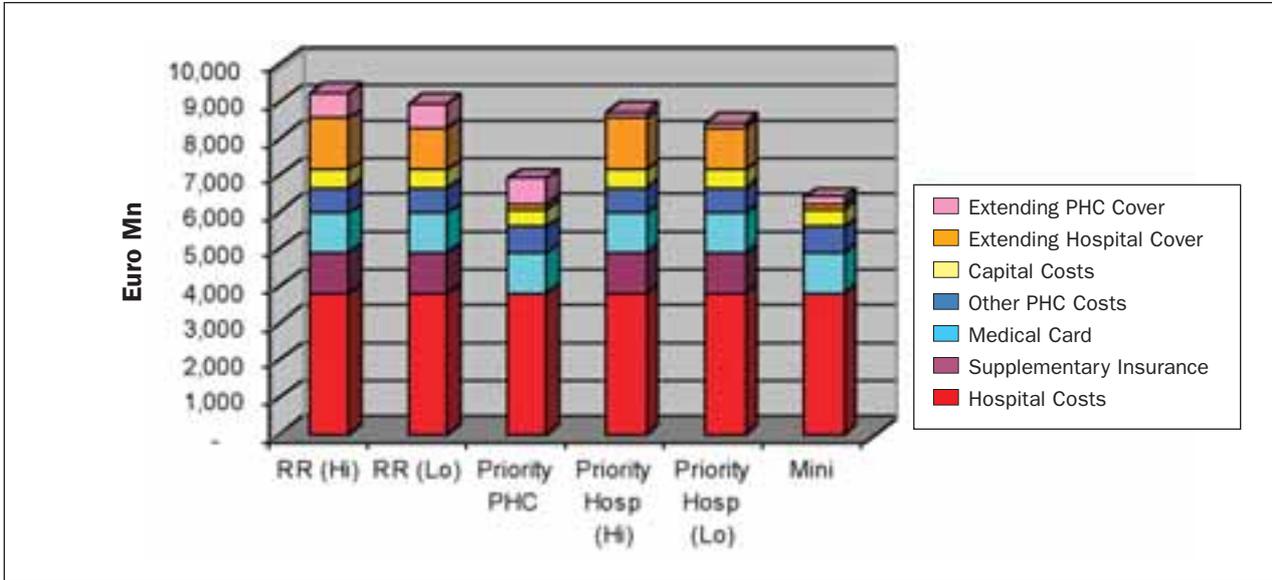
	RR (Hi)	RR (Lo)	Priority PHC	Priority Hospital (Hi)	Priority Hospital (Lo)	Mini
Existing Costs						
Hospital Costs	3,867	3,867	3,911	3,867	3,867	3,911
Supplementary Insurance	1,068	1,068	-	1,068	1,068	-
Medical Card	1,070	1,070	1,070	1,070	1,070	1,070
Other PHC	712	712	712	712	712	712
Capital Costs	467	467	467	467	467	467
Additional Costs						
Hospital Costs	1,392 <sup>1</sup>	1,115 <sup>1</sup>	165	1,392 <sup>1</sup>	1,115	165
PHC Costs	679 <sup>2</sup>	679 <sup>2</sup>	679 <sup>2</sup>	174	174	174
<b>Total</b>	<b>9,254</b>	<b>8,978</b>	<b>6,960</b>	<b>8,749</b>	<b>8,473</b>	<b>6,455</b>

Note:

1. The costs associated with the National Treatment Purchase Fund are removed in the Rolls Royce and Priority Hospital options, as this facility would not be needed.
2. The additional costs for PHC are lower than in Table 4.1 because of the removal of the Drugs Payment Scheme, as this would no longer be necessary. Under the Medical Card all approved prescribed drugs and medicines free of charge.



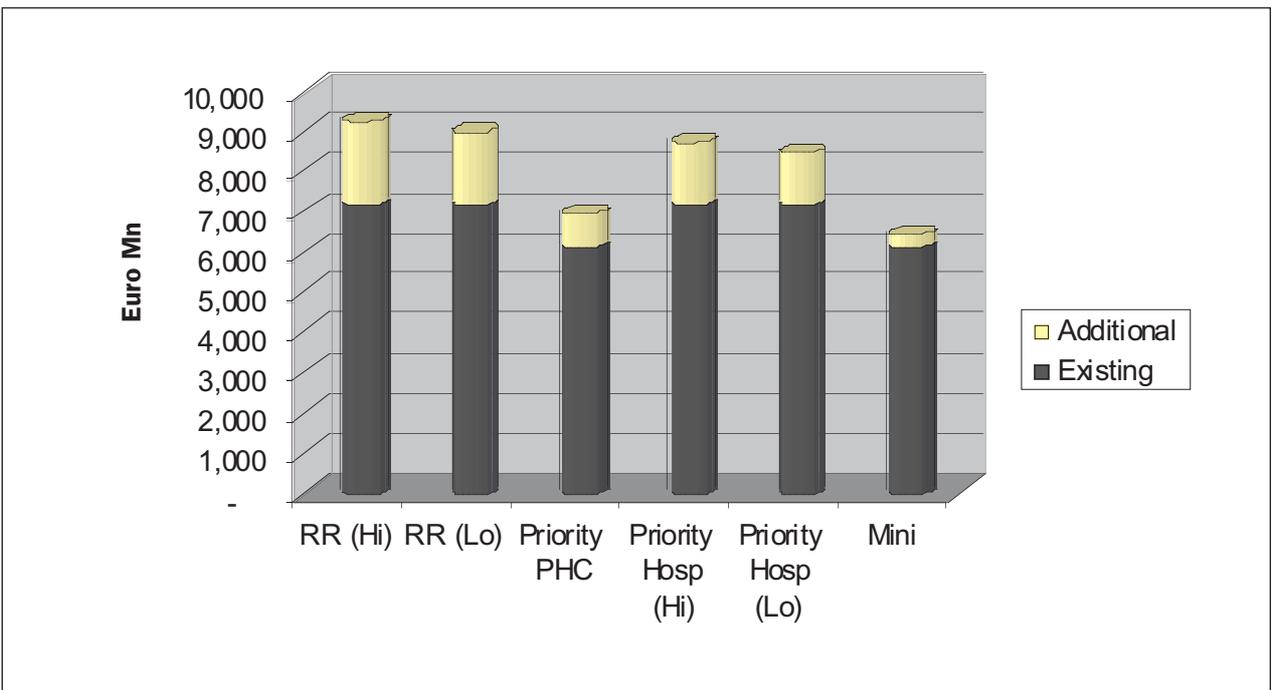
**Diagram 4.1: Projected Costs of the SHI Options, 2004 Prices**



Unsurprisingly, the Rolls Royce option is the most expensive with an estimated maximum price of €9.3 billion for the whole system, though the additional resources required are much smaller. The extension of hospital cover, to bring everyone up to current private insurance care access and service quality, is estimated to cost between €1.1 and €1.4 billion. This estimate is based on a pro-rata projection of the unit cost of existing supplementary insurance to cover the entire population, taking into account utilisation patterns and mix of private and semi-private beds. Once better data are available, more precise calculations will be important to estimate the unmet need in the current system. Further, it may well be that improving the financing and provision of PHC will lower hospital costs and remove some of the current bottlenecks.

The cost of extending the provision of free PHC for all the population of Ireland is estimated at just under €0.7 billion. This is derived from the cost of running the existing Medical Card scheme, taking into account the likely much lower average utilisation of PHC services of the currently uncovered population groups based on their age profile. Hence the additional costs for running the new hospital and PHC packages through SHI are together between €1.8 and €2.1 billion.

**Diagram 4.2: Additional and Existing Costs of the SHI Options, 2004 prices**



**The Priority PHC model** also adopts a free PHC approach and the additional costs of providing this are the same as in the Rolls Royce model, just under €0.7 billion. The policy in relation to the hospital level involves the abolition of charges for access to services for the currently uninsured (non medical card) and the removal of charges for A&E attendance for all the population. Hence the additional hospital costs associated with this model relate to the resources needed to replace the revenue from lost user fees. Our model suggests that around €165 million will be sufficient to cover the lost revenue for hospitals. (It is to be noted that this model assumes that the private supplemental insurance market will continue and fees for the insured are not to be removed.) The additional costs associated with this option are therefore under €0.7 billion. Again it must be noted that these cost estimates do not include any cost reduction to hospitals of having a less constrained PHC system for all the population. Such savings may well be substantial.

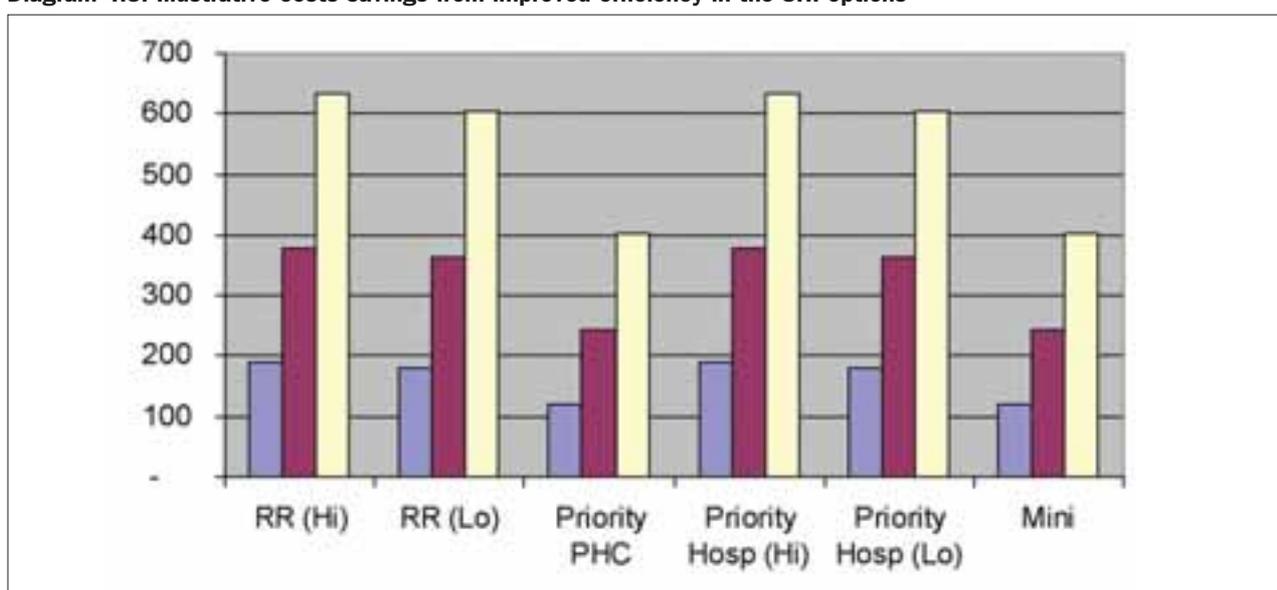
**The Priority Hospital model** is similar to the Rolls Royce option in providing an identical hospital package for all the population, costed at between €1.1 and €1.4 billion. However, the model only provides limited assistance with PHC, through the fixing of the price for a GP consultation at €20 per visit for all those currently without medical cards. The SHI system will provide an additional subsidy to GPs to compensate them for this price fixing. The estimated costs of this PHC subsidy would be approximately €170 million.

**The Mini option** is by far the cheapest model, costing only an additional €339 million. It combines the abolition of IP and OPD charges for the currently uninsured (non medical card) and a reduction of the A&E fee for all, similar to the priority PHC model, with the fixed price approach for PHC outlined above. While the Mini model may appear to be only a limited improvement on the existing services, it may yet remove barriers to access for the currently uninsured who do not have medical cards. As was noted earlier, this group is not receiving fair access to treatment under the current system.

#### Potential Efficiency Gains

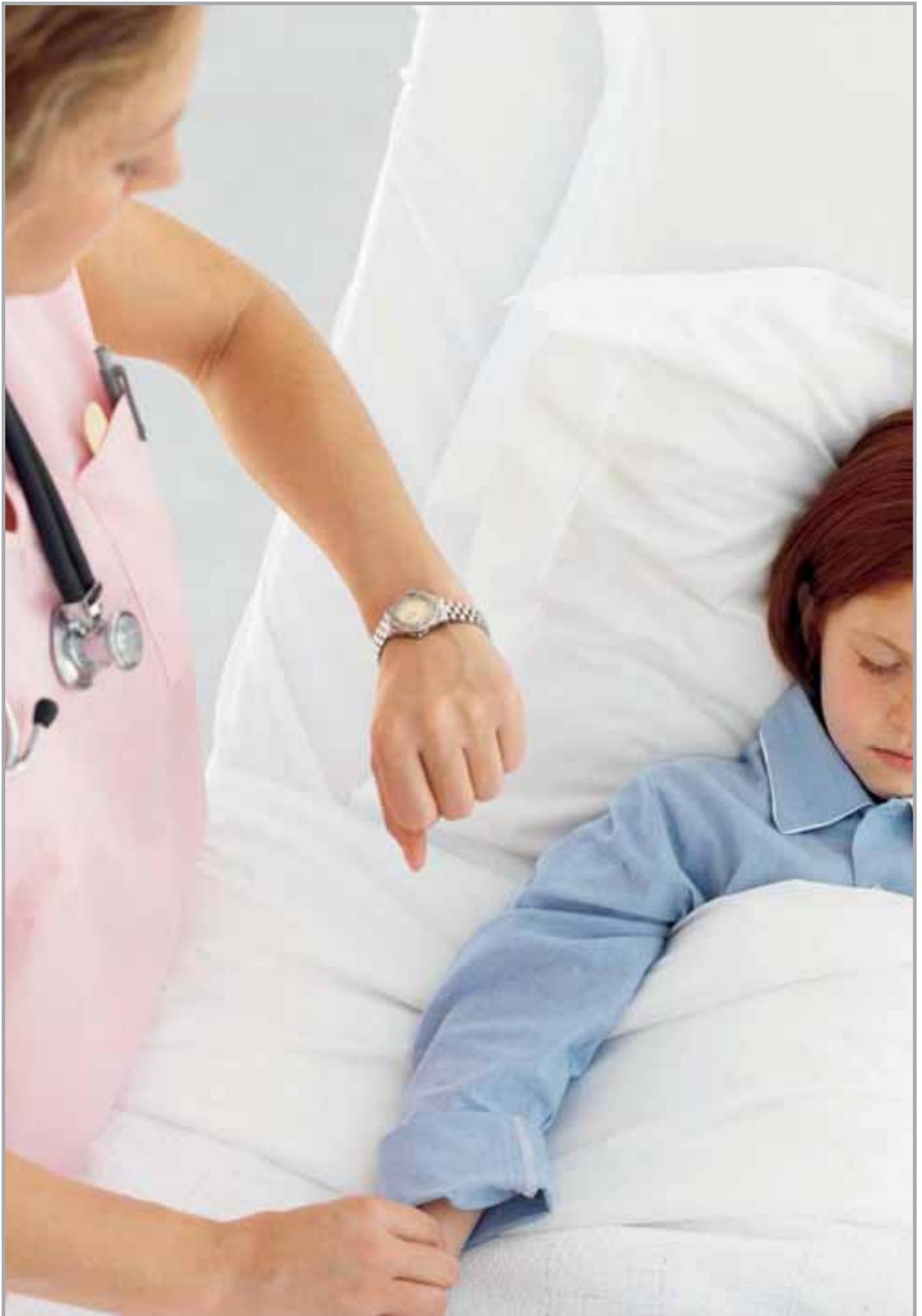
A final cost analysis was done to estimate the impact of moving to more efficient provider payment mechanisms through the use of social health insurance. There is some evidence from the USA that, by moving to case-based payments, costs savings in hospitals are likely (Robinson, 1991). Whether or not such cost savings reduce insurance premia in the long-run in that context is questionable (Hill and Wolfe, 1997). An increasing proportion of Irish hospital budgets are being allocated on the basis of DRGs, making it more likely that there will be substantial efficiency gains on costs, which improves affordability. In Diagram 4.3 below, the authors examine illustrative cost savings under three scenarios, a 3%, 6% and 10% efficiency gain with case-based payments. These rates are of the same order of magnitude as the savings found in Robinson (1991). It is apparent that efficiency gains could in themselves pay for the Mini option. The implications of such efficiency gains on affordability and financing are explored further in Chapter 5.

**Diagram 4.3: Illustrative costs savings from improved efficiency in the SHI options**



A further potential source of efficiency gains is the switch from fee-for-service payment to capitation for paying primary care. A significant (if hard to quantify) amount is spent on the collection of large numbers of relatively small payments. Since it is beyond the scope of this study to look in detail at the costs of primary care practices, the figures suggested below are intended to be illustrative only.

There are few studies that have looked in detail at transaction costs in healthcare. Collection of small amounts from many people is expensive and it is common for such activity to cost 10% of the cost of providing a service. In contrast, capitation payments are calculated only once a year. If the transaction costs of capitation were 5% of the total, this would represent a saving in primary care of around €25 million per annum.



## Chapter 5: The Financing of SHI

### Approach

SHI is a mechanism for achieving policy objectives. Gauging the success of a new SHI system can thus be measured in terms of progress towards meeting policy objectives. In the cases of the re-introduction of SHI in countries in Central and Eastern Europe, the primary objective was to increase the amount and security of the resources for the health sector, and it was accepted that the new arrangements might be less equitable than the tax system they replaced. It would be quite possible to model the introduction of SHI in Ireland to shift the burden of financing health services from relatively richer to relatively poorer people. However, the models presented here are based on the principle that there would be no such shift, since equity is an important goal of the Irish health system. Hence the new SHI arrangements must not harm those on relatively low incomes. Following this principle leads to a model of financing of SHI that is more progressive (in the technical sense that the proportion of income paid rises with income) than most SHI systems in Europe.

There have been many interesting and useful studies of equity in healthcare finance and utilisation and these show that in general the most equitable systems are tax based, followed by those based on SHI. However, such studies inevitably take a partial view – the degree of equity in healthcare finance forms only part of the overall equity in the system of taxes, other mandatory payments, benefits and services. In an ideal world the whole structure of payments and benefits would be constructed in such a way as to meet both efficiency and equity objectives, but the reality is that in any given country at any time it is very difficult to change the basic tax structure. In Ireland there is a generally low level of taxation, and the balance of tax is tilted towards indirect taxation. There is also a system of charging for some services that would in other countries be paid for from tax. (Indeed, the general assumption that tax-based financing of health services is more progressive or equitable than other systems may not hold in the Irish case.) Nevertheless, to make recommendations for major changes in the overall system of direct and indirect taxation is beyond the scope of this study. The approach therefore is to take as given the current arrangements, and to model the introduction of SHI on the following bases:

- Access to services in all models will be improved for at least part of the population, particularly for those without insurance or medical card cover.
- The overall burden of taxation and contributions will not be shifted from relatively richer people to relatively poorer ones.

### A note on the advantages of transparency

There is no system of taxation or mandatory payments that is popular. However, the degree to which people are willing to pay higher taxes and charges can be influenced by greater transparency in the use of the funds collected. An important advantage of SHI is that people are often willing to pay more than they would in general taxation given a sense of greater control over the use of the funds. This greater transparency can also be associated with greater interest by those who contribute (who may be employers as well as employees) in the efficiency of the use of the funds.

It is easy for the advantages of this transparency to be lost, especially if the proportion of total healthcare financing that comes through SHI falls. As noted above, in several countries with SHI systems there is a large tax component in the financing of services, and this breaks the link between the contribution rates and the quantity and quality of services. This point is critical. Since there are some additional costs in running a parallel system of taxation and healthcare finance, it is very important that the advantages of the link between the contributions and benefits be as strong as possible so that people can choose higher payments for better services (or to live with more limited services at lower levels of contributions). For this reason the models of SHI explored in this report are ‘pure’ in the sense that they try to maintain this link as strongly as possible.

In assessing different models of healthcare finance it is important to understand that all resources ultimately come from households, and there is no fundamental difference between paying tax and paying SHI contributions. It therefore makes no sense to subsidise SHI from tax unless this is done to make a particular change to the incidence of the financing (i.e. if it shifts the burden within the population). One reason for the use of tax funds to subsidise SHI is that SHI traditionally has been charged on earned income alone (usually paid by employers and employees) and overall taxation is charged on this as well as on expenditure and some proxies for wealth (such as tax on buying houses). Some SHI systems also receive subsidies from ‘sin’ taxes (i.e. taxes on consumption of health damaging goods). It is possible however to use the narrow base of earned income as a source of contributions for SHI, as long as this ‘tax’ base is not overburdened. The approach taken in this report is to rely mainly on earned income as the base for SHI, but to offset the effects of this by reducing income tax. This allows continued transparency of the SHI financing without putting too heavy a burden on income from employment as the base for contributions.

### Contributions ceilings

The tradition of insurance is that on average you get back what you pay in. Social insurance, despite the principle of paying on the basis of ability to pay, often has a limit above which no further contributions are payable. In this report the interpretation of SHI is that contributions should be made on the basis of ability to pay, and there should be no upper limit. This is in line with the approach of using SHI contributions to replace income tax as a source of healthcare financing, and there is (in principle) no upper limit on payment of income tax in Ireland.



### Financing Rates

The effective financing rates on taxable income for the SHI options are shown in Table 5.1. These rates include the costs of running the existing system and the additional costs associated with each model, as described in Chapter 4. The Rolls Royce and Priority Hospital options also involve replacing, to a large extent, private supplementary health insurance (b). It is assumed, that those who do not pay income tax are exempt from paying contributions to SHI. This preserves the progressive nature of income taxation in the structuring of SHI financing and ensures that the poor are not penalised by the introduction of SHI.

The full rates range from under 26% for the Rolls Royce package to under 17% for the Mini. With an efficiency gain of 10% on hospital costs by using case-based payments, the SHI rates may fall by up to 1.8%. As noted, there is no government subsidy in this model. It is purely financed by contributions from members.

**Table 5.1: Rates on Taxable Income**

	RR (Hi)	RR (Lo)	Priority PHC	Priority Hospital (Hi)	Priority Hospital (Lo)	Mini
Whole	25.6%	24.8%	19.2%	24.2%	23.4%	17.8%
- with EG 3%	25.1%	24.3%	18.9%	23.7%	22.9%	17.5%
- with EG 6%	24.5%	23.8%	18.6%	23.1%	22.4%	17.2%
- with EG 10%	23.8%	23.1%	18.1%	22.4%	21.7%	16.7%

Notes: EG – efficiency gains through case-based payments in hospitals

Nevertheless, the rates shown in Table 5.1 overstate the actual additional burden on tax payers. In these scenarios health services are to be funded by SHI and not through tax, and in some cases not through supplementary private insurance. In such cases, members would be entitled to substantial tax rebates and would not generally, in some scenarios, be paying for supplementary private insurance. Hence, the effective SHI rates are shown, in Table 5.2, in terms of the additional burden on taxable income. Rates vary from an additional 5.7% for the high scenario for the Rolls Royce option, with no efficiency gains, to only 1.2% for the priority PHC option and -0.2% for the Mini, with efficiency gains of 10% from case-based payments. Hence, 10% efficiency gains more than pay for the additional costs associated with the Mini option.

**Table 5.2: Effective Additional Premia (after tax and insurance rebates)**

	RR (Hi)	RR (Low)	Priority PHC	Priority Hospital (Hi)	Priority Hospital (Lo)	Mini
Additional Tax	5.7%	5.0%	2.3%	4.3%	3.6%	0.9%
- with EG 3%	5.2%	4.4%	2.0%	3.8%	3.1%	0.6%
- with EG 6%	4.7%	3.9%	1.7%	3.3%	2.5%	0.3%
- with EG 10%	3.9%	3.3%	1.2%	2.5%	1.9%	-0.2%

Note: The rates for the Mini and Priority Hospital options only cover about half the PHC access costs for non-GMS patients. The remaining costs would still be incurred by the patients.

An alternative financing model would be to introduce government subsidies. In such a case government would pay insurance contributions for all on all income earned below the tax threshold. These payments would be done through general taxation. The effect of this would be to reduce the apparent SHI financing rates (see Table 5.3). However, this is only a sleight of hand as in this case members would also be contributing through their tax payments. Furthermore, such a mechanism may be less transparent than the pure model, as noted earlier.

**Table 5.3: SHI Rates with government subsidy**

	RR (Hi)	RR (Low)	Priority PHC	Priority Hospital (Hi)	Priority Hospital (Lo)	Mini
SHI Rates with Govt Subs	15.0%	14.6%	11.3%	14.2%	13.8%	10.5%
- with EG 3%	14.7%	14.3%	11.1%	13.9%	13.5%	10.3%
- with EG 6%	14.4%	14.0%	10.9%	13.6%	13.2%	10.1%
- with EG 10%	14.0%	13.6%	10.6%	13.2%	12.8%	9.8%

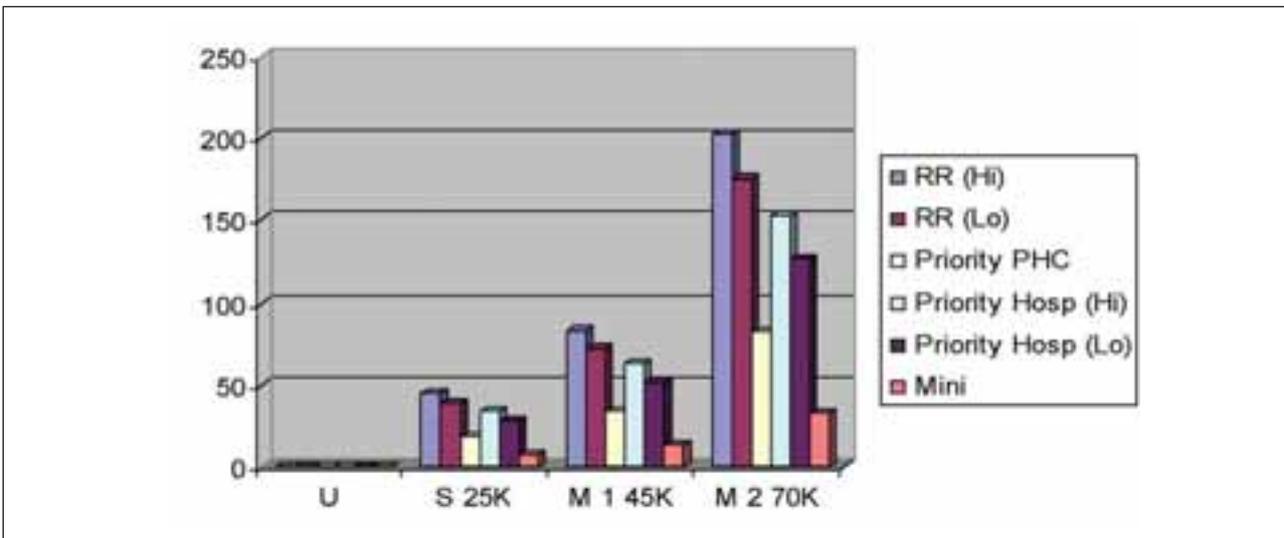
(b) While some market for private insurance may remain, it is assumed it will be much smaller than at present

**Household profiles**

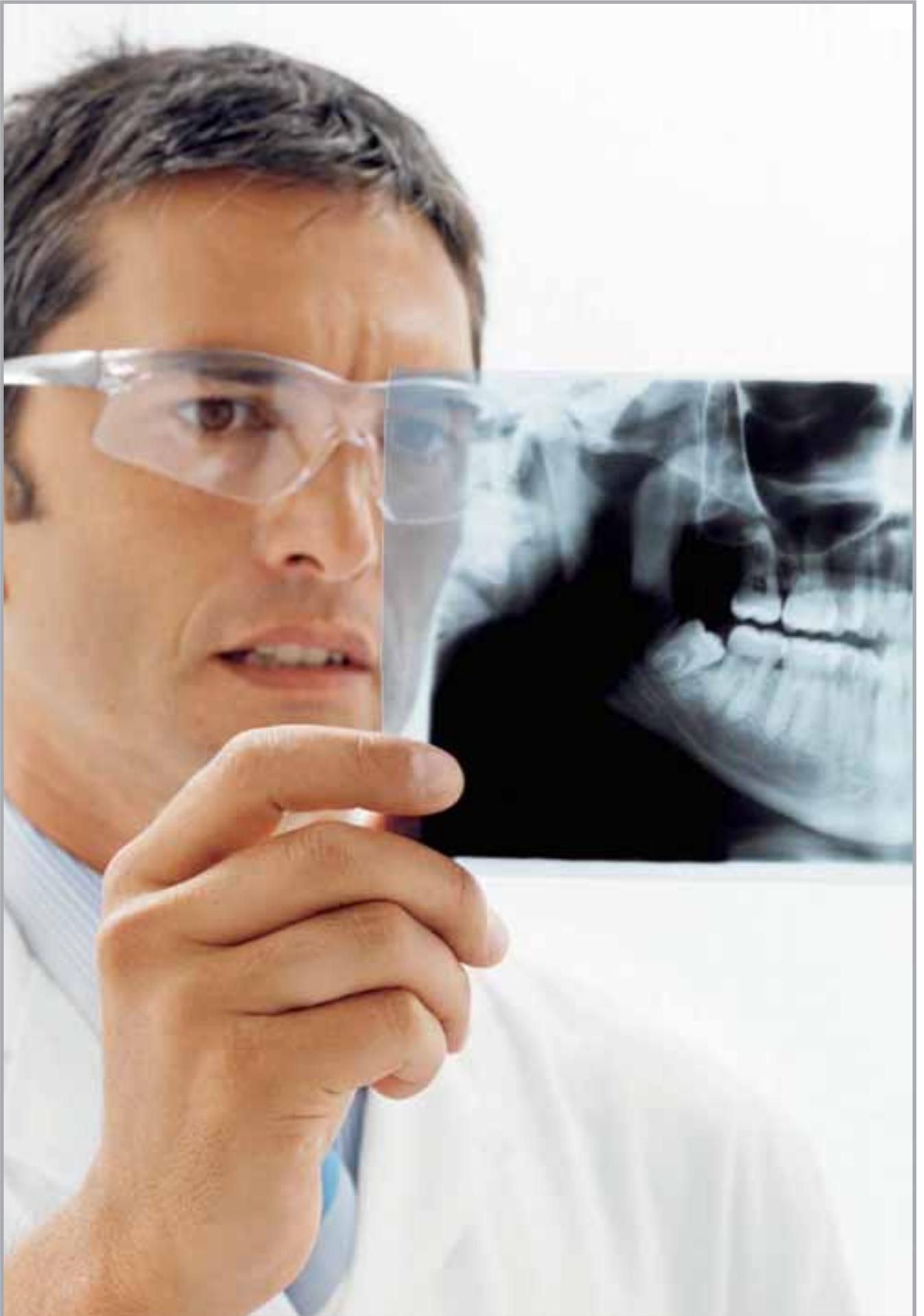
To understand how these rates will affect different groups in the population, the authors calculate the monthly payments required from various household profiles:

- An unemployed person with a medical card.
- A single wage earner, with an income of €25,000, with no medical card and no supplementary insurance.
- A married couple, where one partner earns income, with an income of €45,000 and with supplementary health insurance.
- A married couple, where both partners earn income, with a combined income of €70,000 and with supplementary health insurance.

**Diagram 5.1: Additional monthly costs for the population profiles of each SHI option (2004 prices)**



The additional amounts to be paid by each household are shown in Diagram 5.1. The unemployed person faces no additional costs for any of the options and will get better care with the Rolls Royce and Priority Hospital options. The single person on €25,000 will pay additional monthly amounts ranging from €45 for the Rolls Royce to only €18 for the priority PHC option and €7 for the Mini. At the same time the single uninsured/non medical card person will benefit substantially from all SHI schemes. Indeed, it is this category of person, the uncovered low wage earner, which will probably benefit the most from SHI. While the higher income households will also benefit from the extra services and/or access, particularly around PHC, they must shoulder the burden of the changes to ensure equity of financing. These additional amounts do not take into account any efficiency savings that would reduce the monthly premia from those shown in Diagram 5.1.



## Chapter 6: The Feasibility of SHI

In this section the authors review the potential constraints to the implementation of an effective SHI mechanism to promote government policy. They also review some of the strategies that are on-going or that should be put into place to help alleviate these bottlenecks.

### 1. Political Will and Opposition

As has been noted earlier in the report, it is important to be aware of the political landscape when considering reforms to the financing of healthcare, and particularly those that focus on equity because they tend to be the hardest fought. Changing the composition of health payments and benefits for different segments of the population will create both support and opposition. Vested interest groups are liable to oppose reform unless it in some way meets their objectives. Such opposition can derail reforms as has been seen in other countries, such as the USA and Sweden (Thomas and Gilson, 2004).

Bloom (2001) highlights the importance of the government in such a process to “manage change” toward the achievement of equity objectives. This involves an ability to negotiate with stakeholders and build coalitions. Collins et al. (1999) note the importance of understanding the interests, ideologies, strategies and activities of actors involved in the reform process. Indeed, significant recent effort has been put into “stakeholder analysis”, which involves mapping out the power and interests of actors in the health sector (see Crosby, 1992; Brugha and Varvasozszky, 2000; Varvasozszky and Brugha, 2000). Hence for any policy maker wishing to push through change it is vital to understand the different stakeholders or actors who will be affected by the reform. In particular, key questions relate to:

- Who are the stakeholders?
- What is their current position on the reform?
- What is the basis of their support or opposition?
- How powerful are they?

A stakeholder can be defined as an individual or institution which has an interest in a policy or reform and who is able to influence its design or implementation through his or her actions (Thomas, 2004). Important stakeholders in the Irish context would include:

#### Government Departments and Executives:

- Health Services Executive
- Department of Health and Children
- Department of Finance

#### Politicians: All parties

#### Insurance Industry:

- Vhi Healthcare
- BUPA Ireland
- Other private insurance organisations that provide, or plan to provide, health insurance

#### Providers:

It is not possible to conduct a full stakeholder analysis or consultation process here but it is important to raise some of the obvious concerns of each party from a preliminary investigation of secondary literature and exploratory interviews.

#### HSE

The administrative structures have been going through a painful period of reorganisation with the replacement of the former Health Boards with the new HSE. There would be a need for more and significant changes if the funding role were to be removed and a range of their functions changed. The logic of SHI is for there to be commissioning of services from what are usually fairly autonomous providers, and this would reverse some of the developments at the HSE.

#### Department of Health and Children

SHI would be compatible with the stated policy of improved efficiency and equity. However, it would affect the Department in at least two ways – some control over health policy would be lost, and there would be a need to put in place a wide range of mechanisms and structures to support contracting for services in public providers.

It should also be noted that there is already a commitment to increase the proportion of hospital finance that is based on workload, and there are well established and (by international standards good) systems in place for classifying and costing activity. This would ease the transition to an SHI system.

#### Department of Finance

The key concerns of DoF about SHI typically relate to the effects of an extra payroll tax on the employment market and on the tax burden of individuals and to the principle of having an earmarked tax. Each of these points is explored in turn.



### Employment

Finance may be concerned about the effect of SHI on the labour market if it makes labour more expensive. Payroll taxes may affect employment costs and if not proportionate to pay may make the employment of low cost workers unattractive (Gerard et al, 2004). It should be noted however that much depends on the incidence of the contributions (i.e. are they effectively paid by employers or by employees). Regardless of what is officially the case (i.e. that the contributions are paid by employees or by both) the incidence in the long run depends on how the labour market works and how wages are negotiated.

### Tax Burden

Finance authorities might also be concerned about the overall taxation burden of income earners, arguing that too high a tax regime is a disincentive to extra effort and productivity. If SHI is effectively seen as an additional tax, which is earmarked for health, it might impact negatively on the growth. Nevertheless, the tax burden in Ireland is comparatively low for Europe, with income tax rates being at quite a low level. Indeed, it is interesting to note the desire by the DoF to lower personal taxes further:

“to the extent that there is any scope for personal tax reductions, progress will continue to be made over the three budgets contained within the lifetime of this Agreement towards removing those on the minimum wage from the tax net, moving toward the target where 80% of all earners pay tax at not more than the standard rate.” Sustaining Progress (part 1, paragraph: 3.3.2)

If it is deemed that too many funds are being collected through the payroll, and this puts pressures on employers to decrease employment, then other deduction methods can be increased (such as sin taxes). There is also the option of reducing income tax and replacing it with indirect taxes. It should also be noted that the evidence on the relationship between work effort and direct taxation is ambiguous.

### Earmarked tax

Finance authorities typically dislike earmarked funding. This is funding that doesn't go into the general coffers to be distributed according to the budget process but is allocated to a specific sector or activities. Nevertheless, in the Irish case there is a precedent for this: the Health Levy, which funds a small proportion of public health sector funding. Hence the notion of earmarking funds may not be a problem for the Department of Finance.

### Private Insurers

There is the option that private insurers would play a part in any SHI system, and they could be given opportunities to expand and become more profitable. However, a good system of SHI is likely to reduce or remove the market for supplementary insurance (the current main business) and there is a high chance that insurers would campaign against SHI.

### Providers

#### Hospital managers and boards

Providers in Ireland are used to working mainly within annual budgets, and have not been used to being held accountable for exact volume and range of activities. Under SHI they are likely to be faced with a very close link between activity and income, and much more scrutiny of their performance. While many will happily embrace the opportunities offered, it is likely that others will be hostile to such changes, and there will be some very difficult issues in terms of managing costs related to research and education activities in hospitals, many of which are currently paid from the block grant.

#### Healthcare professionals (especially doctors)

The countries in central Europe that changed to SHI in the 1990s did so with the strong support of (generally badly paid) doctors and nurses. It is not clear that SHI would be supported by professionals and professional bodies in Ireland, who will face the following risks:

- A potential reduction in private practice if public services improve;
- A likely move to doctors being more clearly employees of hospitals and to be accountable for delivery of specific types and quantities of services;
- GPs increasingly working on capped and probably capitation payment.

#### Strategies for Taking Forward Reform

Thomas (2004) suggests the following useful strategies for those policy makers driving financing reform, such as SHI:

- Careful attention to timing and context in assessing when to push forward with reform;
- Learning from past reform processes;
- Minimising discussion with those who will oppose the reform;
- Where this is not possible, discussing and getting buy-in for the principles of reform before working out the implications;
- Developing supportive alliances;
- Mobilising dormant but powerful potential supporters;
- Splitting opposition alliances on critical issues;
- Having room to negotiate away unimportant points;
- Choosing to fight in an arena where the opposition is weaker;
- Undermining the technical foundation of those pursuing opposing visions.

## 2. Administrative Structures and Legal Environment

SHI requires a framework of law to cover structures, procedures, entitlements, and various operational rules. In countries where SHI evolved over many years, such frameworks can seem thin since they are supported by a large amount of custom and practice. Experience in countries that have introduced SHI quickly suggests that it is necessary to be more detailed and explicit.

Enforcement systems are also important in relation to contributions' systems and delivery of care by providers.

SHI can be provided by one or more than one fund. Each fund requires managers with a range of skills in collecting contributions, managing funds, negotiating with providers of care and contracting for supply of services. Some of these currently exist within health services and health insurance organisations, but SHI bodies will need different combinations of skills.

## 3. System Constraints/capacity

It is critically important to have the supply side organised to meet the new demand that will be created by membership in the scheme. The SHI Fund will, under most scenarios, increase the spending power available for healthcare in Ireland and particularly for those segments of the population that have been underserved. Given that there is already a backlog in the system then it will be important to increase capacity so that the SHI doesn't just raise expectations only to dash them. This means addressing bottlenecks both in relation to the physical infrastructure and the human resources to run services.

### Physical Infrastructure

The report from the Commission chaired by Prof. Niamh Brennan noted that evidence presented to the Commission implied both a huge shortfall in hospital beds and an inefficient use of existing beds (Commission on Financial Management and Control Systems in the Health Service 2003: 6). It is important to try to be clear about the gap between:

- current capacity and current potential capacity, with the gains that could be made by better management and allocation decisions;
- current capacity and a needs-based estimate of capacity, in relation to a reduction of waiting lists to an agreed level.

The ESRI's recent report on investment priorities estimates the costs associated with increasing the number of hospital beds under various scenarios (Morgenroth and Fitz Gerald, 2006). Their estimates suggest that an average investment of just under €150 million per year between 2008 and 2013 could fund the necessary increase in bed capacity (assuming 85% bed occupancy and using a 6-year trend analysis model for estimating future use).

### Human Resource Requirements

Similarly while there appears to be a shortfall in the number of human resources in the system, particularly hospital consultants, the Brennan report also questioned whether current levels of human resources were being deployed/utilised efficiently (Commission on Financial Management and Control Systems in the Health Service 2003: 6). A shortfall in numbers would imply the need to boost supply through importing, training or upgrading of certain cadres of health professionals. The question of efficiency in utilisation focuses attention on management, current practices and incentive structures. Such issues need to be explored so that appropriate human resource and financial planning can be put in place.



## Chapter 7: Conclusions

### Basic Features of SHI

Social Health Insurance is not a policy, but a mechanism that can, through greater clarity and transparency, allow policy objectives to be more easily met. The basic characteristics of SHI are that: (i) insured persons pay a regular contribution based on income or wealth; (ii) access to treatment and care is determined by clinical need and not ability to pay; (iii) contributions to the social insurance fund are kept separate from other government mandated taxes and charges; and (iv) the social insurance fund finances care on behalf of the insured persons, and care is delivered by public and private healthcare providers.

SHI systems tend to be associated with high levels of satisfaction in the population. The main arguments in favour of SHI systems are: the potential to provide universal access to healthcare, the acceptability to the public, the transparency of financial flows, the potential to allow diversity and choice in provision and sound financial management. The potential problems are the risk of cost escalation, potentially high management and transaction costs and the need for good accountability. There is also a risk that SHI is too dependent on the payroll for contributions, at a time when the proportion of people with permanent jobs in large organisations is falling.

History and tradition have played very important parts in determining exactly how SHI operates in different countries. There are many variants of SHI, and the performance of SHI systems depends significantly on the detail of the chosen characteristics.

### Irish Healthcare System

The Irish healthcare system is unique in the former EU 15 countries in having no subsidy for access to GP services for the majority of the population, and is unusual in the high proportion of the population that has supplementary private medical insurance. Most of the funding of healthcare comes from government, and this has grown significantly since the late 1990s, but there are important effects on access to care resulting from the relatively small amounts of funds coming from private insurance and user charges.

The patterns of subsidies mean that there are some odd features of the system. Those on very low incomes are winners, but those on fairly low incomes face full or near full cost charges for primary care and those with private medical insurance are subsidised by tax relief on premia and less than full cost charges for private care in public hospitals. The system of 'community rating' in the private medical insurance has inter alia the perverse effect of transferring funds from any young low income members to those who are on average richer, thereby being a serious disincentive to join for young, generally healthy people with low incomes. Yet, perhaps the most serious shortcoming of the current complex set of financing arrangements is that the overall financing burden is not well understood. This leaves many subsidies hidden, perpetuating both inequity and inefficiency in the system.

### SHI Options and Costs

SHI has the potential to improve significantly both the transparency of the current health system and its performance in terms of equity and efficiency. Four designs are developed to move Ireland toward these objectives. The options can be considered as alternatives or stages in a developmental process. All are entirely self-financing in that the costs of maintenance of the system, once up and running, will be met by the contributions of members. There will, however, be need for government to invest in transitional costs. All models improve access to services for at least some of the population.

The four models vary according to the improved access that they give their members in terms of Primary Healthcare, private/semi-private hospital beds and access to consultants. At one extreme the Rolls Royce model gives medical cards to all the population and effectively extends the benefits of private supplementary hospital insurance to all. At the other, the Mini model reduces the financial barriers to access at hospitals for the uninsured and substantially lowers the GP attendance fees for all the population.

The additional costs for implementing the SHI options range from €2.1 billion for the Rolls Royce option to €380 million for the Mini. Such costs can be reduced through efficiency gains associated with the current move toward case-based payments in hospitals.

### Financing

The financing models are based on the assumption that the new SHI arrangements must not harm those on relatively low incomes. There is no upper limit on contributions by the rich and in the preferred scenario members pay all costs associated with the scheme, to help boost transparency and preserve simplicity. This means that a substantial portion of income that currently goes to the general taxation system would instead be paid into an SHI fund. Members would thus pay quite high premia into the SHI fund while also getting a tax rebate and possibly also not purchasing private insurance. The additional payments for the options would range from 6.0% of taxable income for the Rolls Royce option to only 2.5% for the priority PHC option and 1.1% for the Mini. With efficiency gains these rates would reduce so that the Mini option pays for itself and the priority PHC option costs only an additional 1.3% of taxable income.

### Implementation

SHI is a complex reform. Successful policy implementation requires an active government to be able to: (i) understand and manage stakeholder views and opposition, (ii) remove the current capacity constraints in terms of improving



effective management of scarce resources and developing additional infrastructure and training and (iii) construct carefully a legal and administrative framework which can allow SHI to flourish. Further, the transition to such a system needs to be carefully thought through and will entail substantial one-off costs.

#### **Future Research Areas**

It is natural in such a broad-ranging scoping study that there are important areas for future research to develop and refine the findings of this report.

Particularly important areas for further research are the following:

- Further investigation of the incidence of the current financing arrangements and the extent and pattern of public-private subsidy
- More precise costing of the resource requirements to broaden access to the benefits of supplementary hospital insurance cover. (The data gaps for estimating these costs are laid out in the Annex)
- In-depth analysis of stakeholder views and development of strategies to manage the implementation of SHI
- The extent to which the benefits of SHI could be achieved through different mechanisms with smaller changes

## Sources

- Abel-Smith B and Rawal P (1994), "Employer's willingness to pay: the case for compulsory health insurance in Tanzania." *Health Policy and Planning* 9 (4): 409-418
- Barrington, R. (2000). *Health Medicine and Politics in Ireland 1900-1970*. Dublin, Institute of Public Administration.
- Beck RG, Horne JM (1980) Utilization of publicly insured health services in Saskatchewan before, during and after copayment. *Med Care*. Aug; 18(8):787-806.
- Bloom G (2001), "Equity in health in unequal societies: meeting health needs in contexts of social change." *Health Policy*. 57. 205-224
- Brown CV and Jackson PM (1987), *Public Sector Economics*. Third Edition. Basil Blackwell, Oxford.
- Brugha R and Varvasozszky Z (2000), "Stakeholder analysis: a review." *Health Policy and Planning* 15 (3): 239-246
- BUPA (2006), *Rules and Regulations 2006*. BUPA web address. Accessed 28/04/06
- Collins C, Green A, Hunter D (1999), "Health sector reform and the interpretation of policy context." *Health Policy* 47: 69-83.
- Colombo, F and Tapay N (2004). "Private Health Insurance in Ireland: A Case Study." *OECD Health Working Papers* 10.
- Commission on Financial Management and Control Systems in the Health Service (2003). *Report of the Commission on Financial Management and Control Systems in the Health Service*. Department of Health and Children, Dublin Stationery Office.
- Crosby B (1992), *Management and the Environment for Implementation of Policy Change: Part Two, Policy Environment Mapping Techniques, Technical Notes, No 5, Implementing Policy Change Project*. USAID.
- Dept. of Finance (2004). *Revised Estimates of Public Expenditure*. Stationery Office.
- DoHC (2001). *Quality and Fairness: A Health System for You*. Department of Health and Children. Dublin, Stationery Office.
- DoHC 2006a  
[http://www.dohc.ie/public/information/health\\_services\\_in\\_ireland/gp\\_visit\\_cards.html](http://www.dohc.ie/public/information/health_services_in_ireland/gp_visit_cards.html) Accessed 19.05.06
- DoHC 2006b [http://www.dohc.ie/public/information/hospitals/hospital\\_charges.html](http://www.dohc.ie/public/information/hospitals/hospital_charges.html) Accessed 19.05.06
- DoHC 2006c  
[http://www.dohc.ie/public/information/health\\_services\\_in\\_ireland/entitlement\\_to\\_public\\_health\\_services.html](http://www.dohc.ie/public/information/health_services_in_ireland/entitlement_to_public_health_services.html) Accessed 26.05.06
- Donaldson C and Gerard K (1993), *Economics of healthcare financing: The visible hand*. London: Macmillan.
- Gerard K, Mitton C, Jan S, Wiseman V, Donaldson C (2004) *Economics of Healthcare Financing: The Visible Hand*. Palgrave Macmillan.
- GMS (Payments) Board (1998). *General Medical Services (Payments) Board Report for the Year Ended 31st December 1998.*, General Medical Services (Payments) Board.
- GMS (Payments) Board (1999). *General Medical Services (Payments) Board Report for the Year Ended 31st December 1998.*, General Medical Services (Payments) Board.
- GMS (Payments) Board (2000). *General Medical Services (Payments) Board Report for the Year Ended 31st December 2000.*, General Medical Services (Payments) Board.
- GMS (Payments) Board (2001). *General Medical Services (Payments) Board Report for the Year Ended 31st December 2001.*, General Medical Services (Payments) Board.
- GMS (Payments) Board (2002). *General Medical Services (Payments) Board Report for the Year Ended 31st December 2002.*, General Medical Services (Payments) Board.
- GMS (Payments) Board (2003). *General Medical Services (Payments) Board Report for the Year Ended 31st December 2003.*, General Medical Services (Payments) Board.
- GMS (Payments) Board (2004). *General Medical Services (Payments) Board Report for the Year Ended 31st December 2004.*, General Medical Services (Payments) Board.



Government of Ireland. (2001). "Health (Miscellaneous Provisions) Act 2001." Retrieved 25/05/06, 2006, from <http://www.irishstatutebook.ie/ZZA14Y2001.html>.

Harrison MI and Calltorp J (2000), "The reorientation of market-oriented reforms in Swedish health-care." *Health Policy*. 50 (219-240).

Haughton J (2000). *The Historical Background. The Economy of Ireland. Policy and Performance of a European Region*. J. W. O'Hagan. Dublin, Gill & Macmillan: 2-46.

Kutzin J (1995), *Experience with organisational and financing reform of the health sector*. Geneva: WHO

Layte R and Nolan B (2004). "Equity in the Utilisation of Healthcare in Ireland." *The Economic and Social Review* 35: 111-134.

Living in Ireland (2000). *Living in Ireland Survey Data*. Irish Social Science Data Archive.

Living in Ireland (2001). *Living in Ireland Survey*. Irish Social Science Data Archive.

Madden D, Nolan A et al. (2005). "GP Reimbursement and Visiting Behaviour in Ireland." *Health Economics* 14(10): 1047-60.

Maynard A (1996) "Table Manners at the Healthcare Feast: the Case for Spending Less and Getting More." LSE Health Discussion Paper No. 4. London School of Economics. London

McPake B, Kumaranayake L et al. (2002). *Health Economics. An International Perspective*, Routledge.

Mills A (1983), "Economic aspects of health insurance." In Mills A and Lee K (eds.) *The Economics of Health in Developing Countries*. Oxford University Press. Oxford.

Mooney GH (1983), "Equity in healthcare: Confronting the confusion." *Effective Healthcare* 1(4):179-184

Morgenroth E and Fitz Gerald J (eds), "Ex-ante Evaluation of the Investment Priorities for the National Development Plan, 2007-2013" Prepared by the ESRI in association with DKM Economic Consultants. ESRI Policy Research Series No.59. Dublin.

Mossialos E and Dixon A *Funding healthcare: an introduction* in Elias Mossialos, Anna Dixon, Josep Figueras and Joe Kutzin (ed.) *Funding healthcare: options for Europe* Open University Press ISBN 0 335 209246 <http://www.euro.who.int/document/OBS/FHCC01.pdf>

Murray CJL and Frenk J (2000), "A framework for assessing the performance of health systems." *Bulletin of the World Health Organisation*. 78 (6)

NESF (2002). *Equity of Access to Hospital Care*. Forum Report No. 25. Dublin, National Economic and Social Forum.

Nolan, A and Nolan, B (2004). *Ireland's Healthcare System: Some Issues and Challenges*, ESRI.

Nolan B (2005). *Health Insurance in Ireland: Issues and Challenges*, ESRI.

Nolan B and Wiley MM (2000). *Private Practice in Irish Public Hospitals*. Dublin, ESRI.

Normand C (1999), "Using social health insurance to meet policy goals." *Social Science and Medicine* Vol 48 865-869.

Normand C and Busse R (2002). "Social health insurance financing." In Mossialos E, Dixon A, Figueras J and Kutzin J (eds) *Funding healthcare: options for Europe*. Open University Press 2002

Normand C and Weber A (1994), *Social Health Insurance: A guidebook for planning*. World Health Organisation and International Labour Office. Geneva.

NTPF (2006). *A Report on The Patient Treatment Register, The National Treatment Purchase Fund*.

Oliver TR, Dowell E B (1994) "Interest Groups and Health Reform: Lessons from California." *Health Affairs* 13 (4):231-2  
Revenue Commissioners (2004). *Office of the Revenue Commissioners Statistical Report (Year ended 31st December 2004)*, Revenue Commissioners.

Saltman RB (2004). *Social Health Insurance in Perspective: The Challenge of Sustaining Stability*. *Social Health Insurance Systems in Western Europe*. R. B. Saltman, R Busse and Figueras J Open University Press: 3-20.

Saltman R and Figueras J (1997), "European Healthcare Reform: Analysis of Current Strategies." *European Series No. 72*. WHO Regional Publications, WHO Europe. Copenhagen.

- Smith S (2006) Growth in Private Health Insurance and Implications for Equity in Irish Healthcare Financing. Forthcoming submission to Irish Academy of Management Annual Conference, University College Cork, September 2006.
- Smithson P (1996), Health Financing and Sustainability: A review and analysis of five country case studies. Save the Children Fund. Working Paper No. 10.
- Swenson P and Greer S (2002) "Foul weather friends: Big business and healthcare reform in the 1990s in historical perspective." *Journal of Health Politics, Policy and Law*. 27 (4): 605-38
- Thomas S (2003), "Managing Actors in South African Health Financing Reform: Testing a Conceptual Framework." Thesis presented for the degree of Doctor of Philosophy in the Department of Public Health, University of Cape Town. Cape Town.
- Thomas S and Gilson L (2004) "Actor Management in the Development of Health Financing Reform: Health Insurance in South Africa, 1994-1999." *Health Policy and Planning*. 19 (5): 279-291
- Tussing and Wren (2006) *How Ireland Cares: the case for healthcare reform*. Dublin, New Island
- Wagstaff A and Van Doorslaer E (1993). *Equity in the Finance and Delivery of Healthcare: Concepts and Definitions. Equity in the Finance and Delivery of Healthcare. An International Perspective*. E. Van Doorslaer, A. Wagstaff and F. Rutten, Oxford University Press: 7-19.
- Watson D and Williams J (2001). *Perceptions of the Quality of Healthcare in the Public and Private Sectors in Ireland*. Dublin, ESRI.
- Van Doorslaer E and Wagstaff A (1993), "Equity in the finance of healthcare: Methods and Findings. In van Doorslaer E, Wagstaff A and Rutten F (eds.) *Equity in the financing and delivery of healthcare: an international perspective*. Oxford University Press. Oxford.
- Varvasozszky Z and Brugha R (2000), "How to do (or not to do)... A stakeholder analysis." *Health Policy and Planning* 15 (3):338-345
- VHI Healthcare (2003) *Annual Report 2003*. Vhi Healthcare.
- Wagstaff A, van Doorslaer E, van der Burg H, Calonge S, Christiansen T, Citoni G, Gertham U, Gerfin M, Gross L, Häkkinen U, Johnson P, John J, Klavus J, Lachaud C, Lauritsen J, Leu R, Nolan B, Peran E, Pereira J, Propper C, Puffer F, Rochaix L, Rodriguez M, Schellhorn, Sundberg G, Winkelhake (1999), "Equity in the finance of healthcare: some further international comparisons." *Journal of Health Economics* 18: 263-290
- Whitehead M (1992), "The Concepts and Principles of Equity and Health." *International Journal of Health Services*. Vol. 22. No 3. p429-445
- Wiley MM (2001). *Reform and Renewal of the Irish Healthcare System: Policy and Practice. Budget Perspectives Proceedings of a Conference Held on 9 October 2001*. T. Callan and D. McCoy, ESRI: Ch. 4.
- Wiley MM (2005). "The Irish Health System: Developments in Strategy, Structure, Funding and Delivery Since 1980." *Health Economics* 14(Supplement 1): S169-S186.
- Wren MA. (2003). *Unhealthy State: Anatomy of a Sick Society*. Dublin, New Island.
- YHEC (2003). *Assessment of Risk Equalisation and Competition in the Irish Health Insurance Market*. Report to the Health Insurance Authority, York Health Economics Consortium



**Annex: Template for Additional Data Requirements for Estimating the Cost of Scaling up Hospital Insurance Cover**

**Capital Costs:** Could include capacity within private acute hospital sector

Data inputs required for this item include: Current occupancy rates, Target occupancy rates and Forecasts of utilisation (based on demographic profiles etc)

Benefits of Private Acute Care	Action Required	Current Capacity		Additional Bed Capacity Required		Bed Costs		Other Costs	Total Costs
		No. of Private/Semi-Private Beds	No. of Public Beds	No. of Converted Public Beds	Additional Beds	No. of Converted Public Beds	Unit Cost of Additional Beds	Equipment, Theatre Space, Supplies	
<b>Private/semi-private bed</b>	a) Conversion of public wards to private/semi-private wards. b) Additional beds to reduce occupancy rates to internationally accepted levels and to meet current unmet need.								= (unit cost of public ward conversion * no. of required wards) + (unit cost of additional beds * no. of additional beds)
<b>Removal of waiting times</b>	a) Additional capacity to treat more patients at time of referral.				Additional in-patient and day beds				=(unit cost of additional beds * no. of additional beds) + (cost of additional equipment, supplies etc.)
<b>Private 'extras'</b>	a) Provision of luxuries including televisions etc.							TVs etc.	=cost of private extras

**Data inputs required for this item include:**  
 - Current waiting times by specialty  
 - Target waiting times by specialty  
 - Identified gaps in service provision etc

Estimated unit cost of a new acute hospital

**Notes:**

1. Shaded = items which should be included in the total cost calculation.
2. NCHD = Non Consultant Hospital Doctor
3. Above costs do not take into account potential cost reductions in other areas:  
 Reduction of waiting times for hospital care may have an impact on utilisation of GP and other health services (e.g. emergency care).  
 -Efficiency gains can yield improvements in waiting times, bed capacity and staff availability.
4. Tabulating the benefits of private/semi-private care can help prioritise options for SHI:  
 -SHI system can choose to upgrade some or all of the elements included in the above tables (e.g. consultant-provided care only).

## Recurrent Costs:

Benefits of Private Acute Care	Action Required	Additional Capacity Required				Staff Costs				Other Costs	Total Costs	Cost Proxies in SHI Scoping Study	
		No. of Consultants	No. of NCHDs	No. of Nursing Staff	No. of 'Other' Staff	Consultant Unit Cost	NCHD Unit Cost	Nursing Unit Cost	Ancillary Staff Unit Cost				
Private/semi-private bed	Maintenance of additional wards and beds									Estimated cost of staffing and running a new acute hospital bed: €300,000	= Training, education etc.	=(number of staff * staff unit costs for each cadre) + (training costs)	Per night bed charges for private/semi-private accommodation in public hospitals paid by private insurers.
Removal of waiting times	Increased staff numbers at all levels of care and administration										= Training, education etc.	=(number of staff * staff unit costs for each cadre) + (training costs)	Assume this is included in private bed charges.
Consultant Private Care	Increased consultant staff numbers and hours										= Training, education etc.	=(number of staff * staff unit costs for consultant, nursing and 'other' cadres) + (training costs)	Estimated cost of introducing consultant-provided care into the system (National Task Force on Medical Staffing 2003).

## Notes:

1. Shaded = items which should be included in the total cost calculation.
2. NCHD = Non Consultant Hospital Doctor
3. Above costs do not take into account potential cost reductions in other areas: Reduction of waiting times for hospital care may have an impact on utilisation of GP and other health services (e.g. emergency care).  
-Efficiency gains can yield improvements in waiting times, bed capacity and staff availability.
4. Tabulating the benefits of private/semi-private care can help prioritise options for SHI:  
-SHI system can choose to upgrade some or all of the elements included in the above tables (e.g. consultant-provided care only).