ESPN Thematic Report on Inequalities in access to healthcare

Ireland

2018

Mary Daly
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Directorate-General for Employment, Social Affairs and Inclusion
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Contact: Giulia Pagliani

E-mail: Giulia.PAGLIANI@ec.europa.eu

European Commission
B-1049 Brussels

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European Social Policy Network (ESPN)

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Summary / Highlights

Ireland's health system is a centrally-administered national health service delivered through the Health Service Executive (HSE) in public hospitals, health centres and community and social care services. The system is mainly tax funded, with 69.7% of direct funding coming from government sources in 2015 (Central Statistics Office 2017). Only some 0.3% of the public expenditure on health comes from social security or compulsory insurance expenditure. T system is multi-tiered and stratified in several respects. First, there is a strong element of structural inequality since the system is organised on the basis of a divide between public and private patients and services. Those on the lowest incomes - about a third of people – are protected and gain access to services more or less free of charge through a Medical Card while those higher up the income scale pay for GP services and the out-of-pocket expenses that are a core part of the Irish medical service system. There is an 'in between position' whereby those aged over 70, children under 6 and those on low incomes but above the income threshold for the Medical Card obtain a GP Visit Card which allows them free access to GP services. This leaves the rest of the population, the vast majority of whom protect themselves by purchasing private health insurance. This grants them access to both private and public hospitals (where some 20% of beds are designated as private beds) and, in regard to the latter, often preferential and especially more timely access. In all, up to a tenth of the population have no financial cover for medical expenses. Second, entitlement is not clearly defined and the routes to access services and navigate the system are complex and inequitable. Third, Ireland has no universal access to GP services and costs are high. Fourth, the differential reimbursement of GPs, hospital consultants and public hospitals for public patients (fixed remuneration) versus private patients (fee-for-service) creates incentives that favour the latter over the former. In addition to fostering inequalities, this kind of payment structure creates many vested interests.

A second source of inequality is around the supply of services. Historical under-funding together with cut-backs made during the crisis period have meant: a) shortages and rationing in service provision and b) under-development of services in mental health, health promotion and preventive work (*inter alia*). Waiting lists are long – despite some improvements and concerted efforts to cut waiting times. Reforms are stymied, though, by severe cutbacks and underfunding in the period between 2009 and 2015.

There is widespread agreement that the Irish health system needs to be reformed and the direction of travel is towards universal health care. The government in power between 2011 and 2015 was committed to achieving this through the universalisation of private insurance. This proposal failed, for many reasons including the potential costs associated with it, under-specification of key mechanisms and opposition to it from many interest groups. In some senses it was then back to the drawing board. An all-party parliamentary Committee on the Future of Healthcare (2017) provided a blue-print in its report for universal healthcare. It recommended many radical changes, including a re-orientation of the Irish health system towards a single-tier system with universal access based on medical need. Among its key inequality-related proposals are the introduction of a health card scheme which would entitle all residents to access a comprehensive range of services based on need, the introduction of a new model of integrated and coordinated health and social care, the 'disentanglement' of public and private care and the phased elimination of private care from public hospitals.

Recommendations
The Report of the Committee on the Future of Healthcare should be implemented. The government should commit to an implementation plan. The establishment of an Implementation Office as recommended seems especially important.

Plans to extend eligibility for the GP Visit Card to children under 12 should be implemented as soon as possible.

The income thresholds for the Medical Card should be raised so that no-one is excluded from healthcare because of insufficient financial resources. It is also important that careful attention be devoted to the extent and impact of user charges, especially for GP care.

1 Description of the functioning of the country's healthcare system for access

The *Health Act 1970*, as amended, provides the primary legal basis for the provision of specified health and personal social services by the HSE. The services in question are broadly categorised as follows:

In-patient services; Long term residential care services within the meaning of the *Nursing Homes Support Scheme Act 2009*; Out-patient services (defined as "institutional services other than in-patient services provided at, or by persons attached to, a hospital or home and institutional services provided at a laboratory, clinic, health centre or similar premises, but does not include (a) the giving of any drug, medicine, or other preparation, except where it is administered to the patient direct by a person providing the service or is for psychiatric treatment, or (b) dental, ophthalmic or aural services."); Ambulance Services, or other means of transport; General Practitioner medical and surgical services; Supply of drugs, medicines and medical and surgical appliances; Home nursing; Home help services; Medical, surgery and midwifery care for mothers; Medical, surgical and nursing care for infants up to the age of 6 weeks; Payment of a Maternity cash grant; Supply of milk to mothers and children; Child health services; Dental, ophthalmic and aural services and appliances; Rehabilitation services for the training and suitable employment of disabled persons; Screening tests; and Information and advice on health and health promotion programmes. In addition there are services not specifically mentioned in the legislation such as physiotherapy, occupational therapy, speech and language therapy are not specifically mentioned which are now regarded as integral to primary and community care services (Department of Health 2014a).

Ireland's health system is a centrally administered national health service delivered through the Health Service Executive (HSE) in public hospitals, health centres and community and social care services. GPs are private operators and there is considerable private hospital and general health service provision also, making for a purchaser-provider split in these fields. The system is mainly tax funded, with 69.7% of direct funding coming from government sources in 2015 (Central Statistics Office 2017). Only some 0.3% of the public expenditure on health comes from social security or compulsory insurance expenditure, setting Ireland apart from many countries in the EU. Government expenditure on health accounts now for some 9.5% of total government spending and overall health spending in Ireland is higher than in most other European countries (OECD/European Observatory on Health Systems and Policies 2017). However, this is because a significant proportion of health spending is contributed by relatively high out-of-pocket payments (15%) for individuals and households and voluntary prepayment insurance schemes (12%). The latter also distances Ireland from the EU mainstream, playing a considerably larger role in Ireland as compared with elsewhere. There is tax relief for this but employers make no contribution.

The health policy and service situation has been volatile in Ireland, with the recession period seeing considerable change in the level and distribution of health funding since 2008. Budget 2015 was the first year in seven where the health budget was not cut and the country has seen reinvestment in health expenditure since then. Prior to 2015 there had been six austerity budgets in which health spending was especially targeted. From 2009 to 2013 financing of the HSE fell by 22%, amounting to almost €3.3 billion less in public funding (Thomas et al 2014) The reductions to the health budget between 2009 and 2014 were mainly achieved through reducing the HSE workforce (which fell from 112,000 in 2008 to 100,438 in March 2015); reductions in pay for public health system staff; and increased charges, including for those on low incomes (Burke et al 2014; Nolan et al 2014).

There were also some efficiency improvements but overall a noticeable contraction of some services, including those for patients older than 70 years. Rationing and declining breadth and depth of coverage were among other outcomes (Byers 2017). While the budget for 2018 significantly increased the funding to health care – to the order of some 4.4% in the overall allocation - this increase was only 1.6% above the cost of delivering services in 2017 (estimated at approximately €14,318m) and is predicated on making value for money savings of €346m (HSE 2017:1, 68).

Looking back further than the last decade, the long-term story of health services in Ireland is one of under-funding and hence underdevelopment. Among the under-developed areas in the Irish health care system are mental health, disease management, health promotion, community-level services and preventive health care (Byers 2017). All services were considerably expanded and modernised through huge investment during the Celtic Tiger period. However the changes cemented rather than undid the divisions, deepening the dualism in the Irish welfare state as a whole. Hence in health as in other areas of the Irish system, the Celtic Tiger period may have furthered the gap between those maintained by the state through benefits and the better-off who received significant subsidies and top ups to purchase or otherwise avail of benefits and services (especially health insurance, but also pensions, housing and education) from private or quasi-private providers (O'Riain 2014, p. 209). This 'system' ran into trouble during the recession because, while the better off were able to pay the high insurance premiums, those on incomes close to and above the income threshold for the Medical Card were not. At the same time the number of those qualifying for the Medical Card increased hugely as average incomes fell.

In terms of entitlement and access to health care and services, Ireland has neither a stated principle of entitlement nor universal entitlement (even to GP services). There are a few exceptions where a principle of universal access prevails: the maternity and infant care scheme, vaccinations and screening services. In the absence of a principle of entitlement, access is governed by ability to pay (or to be subsidised by the state or private insurance). Because mechanisms exist to subsidise access, in theory there is universal access for all residents to a range of health services in the public system (e.g., inpatient and outpatient treatment in hospitals, pharmaceuticals). In practice though, access is governed by: a) charges, or more specifically ability to pay charges and b) service availability. Both are problematic in a context where no rights to healthcare are enunciated.

Entitlement is characterised by a complex system of eligibility categories (Connolly and Wren 2016a). A first category are Medical Card holders – people who have passed a means-tests (€184 for a single person under 66 living alone, €266.50 for a married couple) - who have more or less free access to both primary care and hospital services and prescribed medicines subject to a charge of €2.50 (now reduced to €2). Currently some 36% of the population fall into this category. The number of people holding a Medical Card has gone up by over 40% over the last decade, despite changes to the entitlement criteria introduced in 2009 to limit access to it (OECD/European Observatory on Health Systems and Policies 2017). A second, related, group are people entitled to a GP Visit Card which gives free GP access. These are people above the income threshold for a Medical Card but still on low income, and, since 2015, all those aged over 70 years as well as all children under 6 years. Some 10% of the population have such a GP Visit Card which means that in all less than half the population have coverage for the costs associated with GP services. The remainder of the population comprises the third category – making up some 54% of the population as a whole they have to pay the full price of GP care (upwards of €50 a time – it should be noted that charges vary and are unregulated) but are entitled to public hospital care, albeit with charges. For example, acute inpatient care requires a co-payment (€80 per day), capped at €800 per year, as do visits to emergency and outpatient departments (€100). Co-payments on prescribed medicines are also applied but are capped at €144 per household per month. Affordability is therefore a major issue in regard to access to health services in Ireland. A sub-grouping of this third grouping – amounting to some 45% of the population as a whole - purchase private insurance to cover these costs. While those with a Medical or GP Visit Card can purchase private health insurance, in practice very few do so (Connolly and Wren 2016b). Depending on the type of premium, insurance grants

entitlement to a range of additional private services as well as faster diagnosis and hospital access. While insurance contributes to the costs for individuals it makes up only around 12% of the funding of the system (although some 45% of people have it). It also fails to prevent Ireland having very high out-of-pocket expenses and may even contribute to these. Take-up of private health insurance in Ireland peaked in December 2008 at almost 2.3 million people, or just over half the population (Turner 2013). Falling rates since could be to do with the high costs and the difficulty on the part of some sectors of the population to afford it. The private health insurance market in Ireland operates on the basis of community rating, open enrolment and lifetime cover (whereby an insurer may not refuse to renew cover). A system of minimum benefits is also specified, although many of these minimum benefits are now out of date.

There are currently four competing companies active in the Irish private health insurance market, including the State-owned VHI and three private health insurers, Laya Healthcare, Aviva Health Insurance and GloHealth. In addition, there are a further seven restricted membership undertakings (RMUs), i.e. bodies that are structured as friendly societies under Irish law and provide health insurance cover for the members of a specific vocational group or employees of a public utility and their immediate families (Department of Health 2014a).Private insurance must cover in-patient, out-patient and day-patient services provided by publicly funded hospitals, private hospitals, registered nursing homes and hospital consultants. Specific minimum benefit requirements apply to maternity care, convalescence care, psychiatric care and treatment for substance abuse (see below). Primary care treatment is not covered by the minimum benefits package unless it is regarded as out-patient treatment provided by a hospital or hospital consultant. However, it should be noted that health insurers can offer packages that exceed the minimum requirements.

The depth of cover is affected by increased user charges. Evidence suggests that the depth of coverage narrowed between 2009 and 2014 with increasing usage of charges, even for Medical Card holders (Burke et al 2016).

A second factor governing access is availability of services. This includes a range of sub factors, including the type, volume and geographic location of services (Committee on the Future of Healthcare, p 17). In regard to waiting lists – which have been the subject of considerable policy reform focus and activity - waiting times are particularly high for outpatient services in hospitals with 10% of patients having to wait more than a year to get first access to services in 2015 (OECD/European Observatory on Health Systems and Policies 2017). Waiting times are also very high for elective surgical procedures, regardless of whether treatment is on an inpatient or day case basis. The OECD/European Observatory on Health Systems and Policies attributes Ireland's relatively low bed capacity a leading role in the waiting times. The number of hospital beds per capita in Ireland is half of the EU average at 2.6 per 1,000 population in 2015 (compared with an EU average of 5.1) (OECD/European Observatory on Health Systems and Policies 2017, p. 7). The low availability of beds when combined with the relatively high hospitalisation rates for conditions that should normally be treated in primary care settings contribute to a very high occupancy rate: 95% of all hospital beds in acute care are occupied on average throughout the year (compared to the EU average of 77%).

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

This section is divided into two: the first looks at the factors and causal patterns associated with inequalities and the second considers how these have been addressed, paying particular attention to reforms. For the purposes of the first section - analysing and identifying the inequity challenges - the discussion differentiates between structural and broader factors. The former relate mainly to the health system itself while the latter relate to broader factors in the environment in which health is determined and the health system operates.

2.1 Inequities in the Irish system

Structurally, the Irish health system has a deep public/private divide running through it. This is true in regard to both funding and services. Among the structural factors that make for inequality are:

- A relatively low proportion of public funding and high out of pocket expenses;
- Wide imposition of user charges;
- A dual system replete with hierarchies and favouring of certain categories and services – the best services and the greatest degree of choice are reserved for those who can afford to pay for themselves or to purchase private insurance. These people have their choice between public and private services and they usually get speedier access in both systems.
- The subsidisation of private health services by public resources. A defining element of the system is that for both primary and hospital care publicly and privately financed care is often administered by the same staff using the same facilities (Connolly and Wren 2016a). All GPs are private operators and have both public and private patients – for the former they are paid on a per capita basis and the latter pay privately (the charges being unregulated). In the hospital sector both public and private providers and services exist and consultants can treat patients on a private basis in public hospitals with some 20% of beds reserved for private patients. A block grant system used to reimburse hospitals for public patients creates an incentive to treat fewer public patients in contrast to per diem charges for private patients.
- Another potential source of inequality is the fact that the private health insurance industry plays an important role in financing (and therefore governing access to) certain types of care particularly in public hospital care (Nolan et al, 2014, p. 151). In this and other ways it could be said to 'punch above its weight' in affecting provision in the Irish medical and healthcare system.

In terms of more general factors making for health inequality, we have to take account of Ireland's relatively high and enduring levels of poverty and income inequality. Irish children are especially vulnerable to poverty and disadvantage, in comparison to the prevalence for adults and also in an EU-wide comparative context. The research on the connection between low income and health deprivation and inequalities is well known (Marmot 2015; Wilkinson 1996). The available evidence confirms health gradient and service use gradient in Ireland in several respects. For example, there is evidence of a six-year gap between the life expectancy of male professional workers and their unskilled counterparts, while the gap for women is 4.8 years (Burke and Pentony 2011). The most recent Healthy Ireland survey (Healthy Ireland 2017), one of the largest social surveys of recent years, finds that while 90% of those living in the most affluent areas perceive their health to be good or very good, only 66% of those living in the most deprived areas do so. Similarly, the *Growing Up in Ireland* study, which tracked a large cohort of Irish children from birth, highlights a widening health and social gap by the time children are just 5 years old (Growing Up in Ireland 2013).

A recent pioneering study of the geographical structure of mortality between 2006 and 2011 found that there exists both: (a) urban, rural, and what the authors term 'isolated rural' variations in age standardised death rates; and (b) sharp health inequalities within Irish cities and, in particular, Dublin (Rigby et al 2017). This suggests the need to attend to gradients and variations at a small-scale local level, although it must be said that the evidence overall (and especially that on unmet need) does not indicate that geographical location is a strong explanatory factor for health inequalities or disadvantage. Rigby et al (2017) attribute the variations they find to a combination of interacting factors: the policies adopted in Ireland especially in the context of relationships between neoliberalism, boom, bust, austerity and recovery on the one hand and the workings of socio-economic

constraints, lifestyle and behaviour, health selection, and the accessibility of health care facilities on the other.

Another important indicator is level of unmet need in healthcare. On this measure in EU statistics Ireland is around the EU average with some 2% reporting such unmet need. However Connolly and Wren (2016b) reported a 4% level of unmet need (on the basis of EU-SILC data for 2013). Ireland is also close to the EU average in terms of changes in levels of unmet need over time - with some rises during the period of the recession and a downward trajectory since. Expense – rather than distance to services – is along with long waiting lists the main reason for unmet health-related need among people in Ireland. Of the two affordability is the more significant causal factor. Ireland is in fact the fifth best member state in terms of level of unmet need, although it performs considerably less well on: mortality amenable to healthcare (10th), total expenditure on health (12th), share of private expenditures (13th), number of consultations per GP (11th) and life expectancy (12th) (Ecorys 2017, p. 79). However it is important to note that the share of unmet need is nearly one-third higher than 10 years previously (OECD/European Observatory on Health Systems and Policies 2017). That said, Ireland is the only EU country where unmet need due to costs for the people in the lowest income quintile is less than for the overall population (1.8% for the lowest income quintile versus 2.0% on average) (ibid). This can be attributed no doubt to the presence (and efficacy) of the subsiding of those on the lowest incomes for the purpose of health service access. The research by Connolly and Wren (2016b) suggests that these people are not fully protected but they point especially to women, lower income groups in general as well as those without a Medical Card or private insurance as most likely to report an unmet health need. In terms of age group, younger people were most likely to report affordability issues whereas for older people it was issues associated with waiting that led to unmet need.

In terms of the usage of services by different sectors, a study by the Irish Pharmacy Union in 2015 (cited in Byers 2017, p. 141) noted significant differences between those with and without Medical Cards in using GP and prescription services. This is to the disadvantage of those who are at the lower middle or around the middle of the income spectrum who may not be able to afford private health insurance and are too young or not poor enough to qualify for a Medical Card or GP Visiting Card. In addition, older research reported that 26% of private patients in Ireland reported having a medical problem but not visiting the GP because of cost (O'Reilly et al 2007). There is also evidence to show that once people over 70 were given a GP Visit Card their usage of GP services increased significantly (Ma and Nolan 2017). In this context it should be borne in mind that up to 10% of the population have no insurance and no Medical Card and that these are more likely than other population sectors to be among those reporting unmet need.

In terms of broader patterns and consequences, a process set in train by cutbacks is cost shifting between public and private funding. Whereas 77% of total health expenditure in 2004 was public money, this proportion decreased to 67% in 2011 (Nolan et al 2014) and has gone up again to near 70% in 2016. It is clear that some transfer of costs from the state onto the people has occurred. Other analysis of the extent of this cost shifting found that between 2008 and 2013, €450 million was transferred from the state onto the people, mainly through the withdrawal of medical cards for those aged over 70 years, increases in hospital charges and prescription charges (Thomas et al 2014). There is an added significance then to the fact that Ireland devotes less public expenditure on health compared to other EU countries (OECD/European Observatory on Health Systems and Policies 2017).

2.2 Reform trends and considerations

It is generally agreed that a health reform programme – and public appetite for such - exists in Ireland, especially since the previous government (a coalition between Fine Gael and Labour) assumed office in 2011, and that this reform programme is quite radical (especially if considered in the context of the orientation to health provision and access over time in Ireland and the slow pace of structural reform). The master documents here

included *Future Health* (Department of Health 2012) - which set out the vision for a single-tier health system to be achieved through universal health insurance – and the White Paper setting out the details of the insurance component of the reform (Department of Health 2014b). Both of these have to be set in the context of the programme for government (Government of Ireland 2011) which, as well as the universal health care reform, laid plans for a more general major reform of service organisation and delivery. The reforms were planned to roll out in three phases.

The first phase was focused on a more efficient delivery of services and involved the setting up of a Special Delivery Unit (which was established in June 2011) and other changes to reduce waiting times for Emergency Department, inpatient and outpatient treatment. Early success is evidenced, with the number of people waiting longer than 12 months for treatment having fallen by 85% and the number waiting longer than nine months having fallen by 91% up to 2012 (O'Sullivan, 2012, cited in Turner 2013). However, since then waiting times have gone up again (OECD/European Observatory on Health Systems and Policies 2017). The latest National Treatment Purchase Fund figures suggest that just over 80,000 people were waiting for treatment as an in-patient or day case at the end of March 2018, a situation that had worsened since December 2015 (when it was just above 68,000). Some 5,497 were waiting for 18 months or more. A further 504,111 were waiting for treatment as an outpatient (15% of whom had been waiting for 18 months or more) (National Treatment Purchase Fund National Waiting List Data 2018). Yet the evidence also suggests some improved efficiencies in the reduction in the unit costs of health system inputs (such as pharmaceuticals and human resources) as well as productivity increases (Nolan et al 2014, p. 157). In assessing how efficient EU health systems are, the Health Consumer Powerhouse reports Ireland scored badly, an outcome caused by 'inefficient, unequal semi-private funding' (Health Consumer Powerhouse 2017, cited in Social Justice Ireland 2018). With reference to efficiency gains – which seem to have stalled since 2013 – the OECD/European Observatory on Health Systems and Policies (2017, p. 15) identifies improving efficiency by moving care to the appropriate setting as one of the main challenges for the Irish health system to.

The second and third reform phases focused on reforming health funding and universalising access. A first reform planned to provide free at the point of use GP care to all of the population by 2015. There was a strong egalitarian orientation here in that the mission was to remove the financial barrier to accessing GP services (so as encourage and enable people to seek treatment at an early stage or at least to remove financial barriers to doing so). This measure was planned to take place on a phased basis eventually covering the entire population. Its story – in short – is of delays (frequently because of legal difficulties) and missed targets, although free GP care was extended to those under 6 and aged over 70 in 2015. The gradual roll-out on a population-wide basis is still planned.

The third phase of the reforms focused on the introduction of the universal health insurance. Under the proposals, while general taxation would remain as the core funding mechanism, it would be obligatory for people to purchase health insurance, which would provide hospital and some primary care cover with the state paying the premiums for those on low incomes and subsidising premiums for a further cohort. It was envisaged that providers would compete to provide value for money. This part of the plan and the idea of market-based compulsory insurance were formally abandoned in 2015. The difficulty – and lack of specification about – getting private providers to compete was one of the reasons why the policy was not pursued. There were other under-specifications as well – for example the basket of services to which the insurance would grant entitlement was never fully specified (Byers 2017, p. 143). The main difficulty, however, was in regard to cost – the original proposal was never costed but an analysis produced in 2015 suggested that the proposed insurance model would increase healthcare expenditure in Ireland by between 3.5% and 10.7% per annum (Wren et al 2015). Other reasons why the proposal failed include opposition among a whole range of interest groups, including those currently paying private insurance who, under the new system, would still have to pay but would lose the 'privilege' of getting fast tracked in the system. According to Byers (2017), the public at large never fully engaged with the proposal as its introduction coincided with

major cut-backs to eligibility and access. In addition, the insurers were concerned about the lack of consideration of the regulatory capital consequences as well as issues in managing costs and the proposed capping of their profits (ibid). Members of the medical profession engaged in private care – the vast majority - were also cool towards the proposal.

However as Burke et al (2016) suggest there occurred a linguistic shift whereby 'universal health insurance' became 'universal healthcare'. The new government in 2016 established an all-party parliamentary committee to develop a reform agenda for the next ten years. In its final report, the Committee suggests a re-orientation of the Irish health system towards a single-tier system with universal access based on medical need. In terms of policy substance towards a comprehensive reform and implementation plan, the report identifies measures structured around the domains of population health, entitlement and access, care integration, funding and governance (Committee on the Future of Healthcare 2017). Health care delivery should take place in primary care and social settings meeting patients' care needs in an integrated way across sectors. Among its proposals are the introduction of a health card scheme which would entitle all residents to access a comprehensive range of services based on need. This it suggests would deal with the lack of a clear statement on entitlement. Other recommendations include the introduction of a new model of integrated and coordinated health and social care, the 'disentanglement' of public and private care and especially the phased elimination of private care from public hospitals[1] and addressing long waiting lists for access to elective care. As regards funding the Committee recommended that a similar level of increase in public investment in health as the last two years - some €380-465 million - should continue at a minimum over the next five years, to support the necessary investment of in the region of €2.8bn over 10 years. In addition, in order to implement system change, it estimates a need for once-off transitional funding estimated at €3bn. The funding is for capital projects, new structures, new equipment, additional staff training capacity and new services. To address geographic inequalities the Committee on the Future of Healthcare recommended the setting up of a Geographic Resource Allocation Formula to ensure equitable allocation of resources based on both population characteristics and activity levels.

Why has it proven so difficult to bring about change? A first reason is that there is little or no history of universalism in the Irish experience of welfare. Against a context of underdevelopment, the long story is of piecemeal and often group-specific reform. Philosophically a predisposition existed in Ireland towards a libertarian perception of healthcare as a marketable commodity rather than a social right (Wren and Connolly 2017: 4). In addition, there are many stakeholders with entrenched interests, among them some members of the medical profession and also insurance providers who have privileged position to protect. In addition the recent failed attempt at reform suggests that that there were design weaknesses, such as lack of clarity and depth on key matters (ibid). These may reflect underlying unresolved conflicts in society at large about key values and the role of the state. And yet there is a public appetite for reform and high levels of public support for universal healthcare. Darker et al (2018) find some 87% of people support universal healthcare. While the government welcomed the report at the time little has happened in the interim to implement it.

Recommendations

The Report of the Committee on the Future of Healthcare should be implemented as soon as possible. The government should set out and commit to an implementation plan, using the very helpful calendar provided by the Committee. The establishment of an

[1] See the response of the Irish Medical Organisation (2018) to this. It suggests that the proposal is based on a number of flawed assumptions and lack of evidence, especially that expecting that the removal of private beds from public hospitals would generate greater public healthcare capacity. The IMO is of the view that the most effective way to improve public hospital capacity is to expand existing bed numbers and staffing, which can reduce bed occupancy below 85% to ensure patient safety and provide for seasonal increases in demand.

Implementation Office as recommended seems especially important. The Committee requested that this be set up by July 2017 and be under the auspices of the Taoiseach.

Plans to extend eligibility for the GP Visit Card to children under 12 – which have currently been stalled until the successful negotiation of a new GP contract - should be implemented as soon as possible. Connolly et al (2018) estimate that this would add between 2 and 3.5% to overall public healthcare expenditure and up to 1.2% to total healthcare expenditure. This relatively modest increase in total healthcare expenditure would go a long way towards increasing universality in the Irish healthcare system. However this strategy is only one and should be considered in the context of adequate resourcing of the primary care system more broadly.

The income thresholds for the Medical Card should be raised so that no-one is excluded from healthcare because of insufficient financial resources. Careful attention should be devoted to the extent and impact of user charges in any proposed reform of the health system, especially for GP care.

3 Discussion of the measurement of inequalities in access to healthcare in the country

The data available through the EU-wide sources mentioned in the Guidelines are all helpful for Ireland. But there are a few additional pieces of information that are relevant. In particular we need a better breakdown by socio-economic status of all service use and more granular detail on the users of private services as against public health services by socio-economic status but also by health status – Medical Card holders, GP Visit Card holders, private insured, others who have no insurance or subsidised access. This is vital information if we are to understand the particularities of the stratification in the Irish system.

In terms of national information, the report of the Committee on the Future of Healthcare (2017: 104) points out that much of the information on the functioning of the health system in Ireland is held within individual organisations and branches of the system. Therefore a significant challenge is to effectively use data from multiple organisations. The Committee emphasised the need to decide on a common unit of geography across organisations involved in health research. In this regard it suggested using the Community Health Network as the appropriate population level unit for the collection and integration of health data. In terms of local level data, the work of Rigby et al in producing a series of datasets which identify and classify some 407 local areas (intermediate in size between counties and electoral divisions) in regard to mortality is an important contribution.

The last ten years have seen a number of initiatives to produce analyses which relate to health inequalities and to make these available on interactive portals. These include:

- The Irish Health Poverty Index of the Institute of Public Health in Ireland (https://www.publichealth.ie/files/file/HSE%20Health%20Inequalities%20Subgroup%20Meeting%2021%20May%20-%20iHPI%20Briefing.pdf
- Health Atlas Ireland (https://www.healthatlasireland.ie)
- Pobal maps – a free Geographical Information System which provides local area deprivation and service profiling (https://maps.pobal.ie/).

Among other possible national sources that could yield information on health inequalities are:

- Irish Longitudinal Study on Ageing (TILDA) which collects information on all aspects of health, economic and social circumstances from adults aged 50 years and over resident in Ireland. Waves of data collection take place every two years (with some

8,000 participants).[2] Among the themes it gathers information on are biomarkers, economics, frailty and resilience and service use.

- Growing Up in Ireland Panel Study which is the national longitudinal study of children and youth which started in 2006 and follows two cohorts of children aged 9 years (child cohort) and 9 months (infant cohort). Currently the members of the Child Cohort are 20 years old and the Infant Cohort are 9 years old. Among the topic covered are development health and well-being and a particular objective is to understand the factors and processes that lead to social disadvantage and exclusion.[3]
- All-Ireland Traveller Health Survey which is a once-off study of Travellers on the island of Ireland carried out between 2007 and 2010.[4] The main topics covered include health, health service utilisation, accommodation and living conditions, social support, experience of racism and discrimination, diet and eating patterns, alcohol consumption. Smoking, drug taking, exercise.

[2] See https://tilda.tcd.ie/

[3] See http://www.esri.ie/growing-up-in-ireland/about-growing-up-in-ireland/

[4] See http://www.ucd.ie/issda/data/allirelandtravellerhealthstudy/

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